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Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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General Comment

Attached are comments submitted on behalf of America's Health Insurance Plans in response to the Request for Information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Please contact me if you have any questions.

Attachments

EBSA-2009-0010-DRAFT-0260.1: Comment on FR Doc # E9-9629
EBSA-2009-0010-DRAFT-0260.2: Comment on FR Doc # E9-9629

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May 28, 2009

Submitted via the Federal eRulemaking Portal: www.regulations.gov

Attn: MHPAEA Comments
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Attn: CMS-4137-NC
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8010

CC:PA:LPD:PR (REG-120692-090)
Room 5205
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Request for Information Regarding the Paul Wellstone and
Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
74 Fed. Reg. 19155 (April 28, 2009)

Dear Sir/Madam:

America's Health Insurance Plans (AHIP) is writing to offer comments and recommendations regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. Law No. 110-343, the "MHPAEA"). We are responding to a Request for Information (RFI) published in the *Federal Register* on April 28, 2009 (74 Fed. Reg. 19155). AHIP strongly supported the MHPAEA and worked with a broad coalition of stakeholders in developing the legislation.

AHIP is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace and also have demonstrated a strong commitment to participation in Medicare, Medicaid, and other public programs.

We have attached the following materials in response to the RFI.

- A discussion document addressing how mental health and substance use disorder benefits are currently covered by group health plans and group health insurers and offering recommendations on implementation of the new requirements (Attachment 1).

- A draft set of "Frequently Asked Questions" on the MHPAEA that could be used to educate consumers, health care providers, employers, third-party administrators, and health insurance plans on the requirements of the MHPAEA (Attachment 2).

- A chart outlining state insurance laws governing the provision of mental health and substance use disorder benefits (Attachment 3).

AHIP's recommendations for implementing the MHPAEA, as set out in the attached discussion document, address the following issues:

- Application of the new requirements to group health plans and group health insurance.

- Determining parity with respect to financial requirements and treatment limits between medical/surgical benefits and mental health/substance use disorder benefits.

- Defining when the MHPAEA exclusion applies in the case of a small employer.

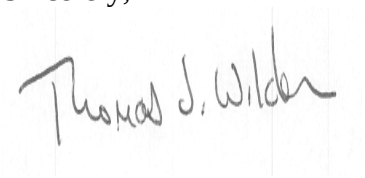
- Disclosing information to consumers and health care providers on the application of medical necessity criteria.

- Considering preemption of state parity requirements.

AHIP and its member health insurance plans believe the MHPAEA will assure Americans greater access to behavioral health and substance use disorder coverage while continuing to promote high-quality, evidence-based care. We look forward to working with the federal agencies on this critical issue.

Please feel free to contact me at (202) 778-3255 or twilder@ahip.org if you have any questions.

Sincerely,



Thomas J. Wilder
Senior Regulatory Counsel

Attachments:

Attachment 1

America's Health Insurance Plans
Response to Request for Information
Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

May 28, 2009

America's Health Insurance Plans (AHIP) is writing to provide the following comments and recommendations regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. Law No. 110-343, the "MHPAEA"). We are responding to a Request for Information (RFI) published in the *Federal Register* on April 28, 2009 (74 Fed. Reg. 19155). Our comments below discuss how coverage is currently provided by group health plans and group health insurance for mental health and substance use disorder benefits and provides recommendations with respect to implementation of the new requirements.

Coverage for Mental Health and Substance Use Disorder Benefits

Almost all individuals with employer-based health benefits have coverage for mental health and substance use disorder benefits. The most recent Kaiser Family Foundation/HRET Employer Health Benefits Survey indicates that 98% of covered workers have coverage for mental health benefits.[1] According to data from the U.S. Bureau of Labor Statistics, the number of employees with employer-provided coverage for alcohol and drug rehabilitation benefits ranged from 83% (for in-patient services) to 87% (for out-patient services) in 2002, the last year for which data was available.[2]

Over the past few years, health insurance plans have adopted a variety of approaches to coverage for mental health and substance use disorder benefits. For example, many health insurance plans provide case managers to coordinate medical, behavioral health, and social services needed by patients. In addition, health insurance plans promote access to a wide range of treatment settings including residential treatment facilities, partial hospitals, intensive-outpatient programs, and care provided through primary care physician offices.[3]

Coverage for mental health and substance use disorder benefits provided through health insurance is frequently based on state mandates. We have attached a chart outlining state requirements governing coverage of mental health and substance use disorder benefits

[1] Kaiser Family Foundation/Health Research & Education Trust, *Employer Health Benefits 2008 Annual Survey*, available at: http://ehbs.kff.org/
[2] John Morton and Patricia Aleman, *Trends in Employer-Provided Mental Health and Substance Abuse Benefits*, Monthly Labor Review (April 2005), available at: http://www.bls.gov/opub/mlr/2005/04/art3full.pdf
[3] These approaches are discussed more fully in a paper from the AHIP Center for Policy and Research, *A New Generation of Behavioral Health Coverage: Perspectives from Interviews with Medical Leader* (June 2007), available at: http://www.ahipresearch.org/

(Attachment 3). Forty-nine states have enacted mental health benefit mandate laws and forty states either include treatment for substance abuse benefits in such laws or have enacted separate requirements applicable to the group insurance market. These state laws impose significant requirements regarding the types of benefits that must be covered and the scope of financial requirements and treatment limits.

Recommendations for Implementation of the MHPAEA

Implementation of the parity requirements in the MHPAEA is a significant undertaking by group health plans and group health insurers. As discussed below, some group health plans and group health insurers have already begun negotiations for health benefits for the 2010 plan year or have finalized their contracts. As a result, it is important that implementation guidance be released as soon as practicable, to be followed by regulations. We offer the following recommendations for guidance and regulations with respect to implementation of the new requirements.

A. Streamlining Implementation of the MHPAEA

Issue A1: Provide clear and concise guidance to assist consumers, health care providers, employers, third-party administrators, and health insurance plans with understanding the MHPAEA requirements.

Discussion A1: The MHPAEA is effective for most group health plans and group health insurance for plan years that begin on or after October 3, 2009.[4] Many health insurance plans are already in negotiation with employers for health coverage that will begin after the MHPAEA effective date and, in some cases, those contracts are finalized. Health insurers are in the process of submitting insurance policy changes to comply with the MHPAEA requirements to state regulatory agencies for approval.

As a result of the on-going negotiations between employers and health insurance plans and the time needed to obtain state regulatory approvals for insurance policy changes, it is critical that guidance be provided in a timely manner for consumers, health care providers, employers, third-party administrators, and health insurance plans. We recommend that guidance in the form of "frequently asked questions" (FAQs) be released first to address the priority issues with respect to the MHPAEA, followed by proposed rules allowing sufficient time for public comment. The guidance and regulations from the Centers for Medicare & Medicaid Services (CMS), the Employee Benefits Security Administration (EBSA), and the Internal Revenue Service (IRS) on the 1996 Mental Health Parity Act provide a good framework for future regulatory activity (S*ee:* Tres. Reg. §54.9812-IT, 29 C.F.R. §2590.712, and 45 C.F.R. §146.136).

The guidance and regulations should provide clear and concise information on the application of the MHPAEA and include examples of different scenarios with respect to

[4] In the case of group health plans maintained pursuant to one or more collective bargaining agreements, the MHPAEA is effective for plan years beginning after the latter of: (a) January 1, 2010; or (b) the date on which the last collective bargaining agreement relating to the plan terminates.

the application of financial requirements and treatment limits. We have attached a draft set of FAQs (Attachment 2) that may serve as an outline for the initial guidance on implementation of the MHPAEA.

AHIP recommends that guidance, in the form of frequently asked questions, should be released as soon as practicable to assist the effective implementation of the MHPAEA, followed by proposed regulations with a comment period. The guidance and regulations should provide clear and concise information for consumers, health care providers, employers, third-party administrators, and health insurance plans on the MHPAEA requirements.

Issue A2: Provide compliance-based enforcement in situations where good faith efforts have been made to implement the MHPAEA.

Discussion A2: As noted, there may be cases where group health plans and group health insurers have already established contracts for health benefits for plan years beginning on or after October 3, 2009. These agreements may be based on insurance policies approved by state insurance regulators. Given the complexity of the MHPAEA requirements, CMS, EBSA, and IRS should work with group health plans and group health insurers to bring them into compliance with the MHPAEA. We believe compliance-based enforcement is appropriate when group health plans and group health insurers are working in good-faith to implement the new requirements.

A similar approach to enforcement was taken by the U.S. Department of Health and Human Services' Office for Civil Rights (OCR) during the initial period after adoption of the privacy rule promulgated under the Health Insurance Portability and Accountability Act (HIPAA).[5] OCR recognized that the new rules, which govern the collection, use, and disclosure of protected health information by health care providers, health plans, and health care clearinghouses, raised a number of significant and complex administrative issues for regulated entities. As a result, OCR determined that assisting covered entities with their compliance responsibilities was a more effective means of enforcement than assessing fines.

We are not asking CMS, EBSA or IRS to forgo their oversight responsibilities. However, we recommend that the regulatory agencies take into consideration that group health plans and group health insurers are working diligently and in good faith to provide health coverage in full compliance with the MHPAEA in the absence of guidance on many critical issues.

AHIP recommends that CMS, EBSA, and IRS adopt a compliance based approach to enforcement of the MHPAEA and that the agencies work with group health plans and group health insurers on implementation of the requirements. Group health plans and group health insurers that are working in good faith to comply with the MHPAEA should not be penalized during the first year after the effective date of the legislation.

[5] 45 C.F.R. Parts 160 and 164.

Issue A3. Allow group health plans and group health insurers to meet their obligations to provide information to consumers about medical necessity criteria through compliance with existing ERISA requirements.

Discussion A3: The MHPAEA requires group health plans and group health insurance to provide certain types of information to consumers and health care providers:

> Availability of Plan Information – The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) or reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(29 U.S.C. §1185a(a)(4) and 42 U.S.C. §300gg-5(a)(4) as amended by Pub. Law No. 110-343).

Group health plans are subject to extensive disclosure requirements under ERISA including requirements governing the disclosure of information to participants and beneficiaries when enrolled in a plan. Plans must provide participants and beneficiaries with a summary plan description (SPD) including a description of benefits provided under the plan, any cost-sharing requirements, descriptions of providers and provider networks, and "any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan." (29 C.F.R. §2520.102-3(j)(3)).

In addition, group health plans are required by the ERISA claims rule to provide the following information to participants and beneficiaries:

> In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,
>
> (A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline,

protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(29 C.F.R. §2560.503-1(g)(v)).

We believe the MHPAEA requirements to inform participants and beneficiaries regarding medical necessity criteria under the plan are met when a group health plan complies with the ERISA requirements to provide the SPD and to provide information in the case of an adverse benefit determination.

AHIP recommends that guidance and regulations clarify that group health plans and group health insurers are in compliance with the MHPAEA requirements to inform participants and beneficiaries regarding the use of any medical necessity criteria by following the ERISA rules for providing SPDs and for informing individuals concerning an adverse benefit determination.

B. Establishing the Framework for Applying the MHPAEA

Issue B1: Clarify the group health plans and group and individual health insurance that are subject to the MHPAEA.

Discussion B1: As discussed, the MHPAEA applies to group health plans and group health insurers subject to ERISA and the PHSA. Clear guidance should be provided to define which group health plans (and health insurers offering coverage to group health plans) are required to comply with the MHPAEA. This guidance should expand on the information currently available from CMS and EBSA with respect to the application of the 1996 Parity Act to certain entities. We have included a chart at the end of this discussion document outlining the application of the MHPAEA to group health plans and group and individual health insurance.

AHIP recommends that guidance be provided to define the application of the MHPAEA to group health plans and group and individual health insurers.

Issue B2: Clarify that group health plans that offer benefits only for retirees are not subject to the MHPAEA.

Discussion B2: ERISA, IRC, and the PHSA exempts the application of the MHPAEA in the case of "any group health plan (and health insurance coverage offered in connection

with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees . . . ." (S*ee:* 26 U.S.C. §9831(a)(2), 29 U.S.C. §1191a(a), and 42 U.S.C. §300gg-21(a)).

In some limited situations, an employer that offers health coverage to retired employees and to their family members may choose to establish a separate group health plan to provide such benefits. Because these group health plans have fewer than 2 participants who are current employees, the plan (and any health insurance offered to such plan) is not subject to the MHPAEA.

AHIP recommends that guidance be provided to clarify that a "retiree-only" group health plan that has fewer than 2 participants who are current employees is not subject to the MHPAEA.

Issue B3: Provide clear definitions to determine if an employer has 50 or fewer employees on an annual basis.

Discussion B3: The 1996 Parity Act exempts employers that employ between 2 and 50 employees on an annual basis. This requirement was modified by the MHPAEA to also exempt employers with one employee in those states that recognize "groups of one" for purposes of group health insurance laws.

The current rules establish requirements to determine when an employer is employing between 2 and 50 employees on an annual basis and are therefore exempt from the parity requirements. This rule should be retained with a modification to include the changes for employers with one employee.[6]

AHIP recommends that guidance and regulations provide a clear definition to determine if an employer has between 1 and 50 employees on an annual basis. The current rule should be retained with a modification to include employers with one employee.

Issue B4: Clarify whether employee assistance programs (EAPs) are governed by the MHPAEA.

Discussion B4: Employee assistance programs (EAPs) are established by employers to provide a variety of ancillary services to employees and their family members including legal advice, financial planning, wellness promotion, and counseling. In some cases, these services may be used to address behavioral health or substance abuse issues. It is not entirely clear whether EAPs would meet the ERISA definition of a group health plan. We believe that in most cases, even if the EAP is considered to be a group health plan, the EAP does not provide medical and surgical benefits and, as a result, is not subject to the MHPAEA.

[6] S*ee:* Tres. Reg. §54.9812-IT, 29 C.F.R. §2590.712, and 45 C.F.R. §146.136.

AHIP recommends that guidance and regulations define the situations (if any) under which an EAP would fall under the definition of a "group health plan" for purposes of the MHPAEA. The guidance and regulations should also clarify that if the EAP is a group health plan, it must provide mental health or substance use disorder benefits and medical and surgical benefits in order to be subject to the parity requirements.

Issue B5: Clarify the application of the preemption provision.

Discussion B5: The MHPAEA preempts state parity requirements applicable to group health insurance in some situations. The preemption provisions are included in the 1996 Mental Health Parity Act which amended HIPAA:

> (1) In general
>
> Subject to paragraph (2) and except as provided in subsection (b) of this section [regarding portability of insurance coverage], this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirements solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.
>
> (2) Continued preemption with respect to group health plans.
>
> Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

(29 U.S.C. §1191(a)).

The MHPAEA preempts state laws that "prevent the application" of the federal parity requirements. In addition, the preemption provision recognizes the general principle that states may not regulate ERISA group health plans.

AHIP recommends that guidance and regulations clarify that state laws applicable to group health insurance are preempted if they prevent the application of the federal parity requirements in the MHPAEA and that states may not regulate group health plans.

C. Determining Parity With Respect to Financial Requirements and Treatment Limits

Issue C1. Clarifying that group health plans and health insurance issuers may impose separate financial requirements and treatment limits with respect to medical and surgical benefits and mental health or substance use disorder benefits.

Discussion C1: The MHPAEA sets out the following requirements with respect to parity between medical and surgical benefits and mental health or substance use disorder benefits:

(A) In General – In the case of a group health plan (or health insurance coverage ordered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that --

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) 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 and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(29 U.S.C. §1185a(a)(3) and 42 U.S.C. §300gg-5(a)(3) as amended by Pub. Law No. 110-343).

A "financial requirement" is defined in the MHPAEA as including deductibles, copayments, coinsurance or out-of-pocket expenses. A financial requirement does not include an annual or lifetime dollar limit on benefits covered by the 1996 Parity Act. A "treatment limitation" is defined by the MHPAEA as a limit on the frequency of treatments, number of visits, days of coverage or other similar limits.

The MHPAEA is intended to provide patients with access to mental health or substance abuse disorder benefits on the same basis as coverage for medical and surgical benefits with respect to any applicable financial requirements or treatment limits. There are a number of approaches to reaching this goal:

- A group health plan or group health insurer could choose not to impose any financial requirements or treatment limits.

- Financial requirements or treatment limits could be applied by the group health plan or group health insurer only to medical and surgical benefits and not to mental health or substance use disorder benefits.

- The financial requirements or treatment limits applied to mental health or substance use disorder benefits could be the same as or more favorable to

the patient than the financial requirements or treatment limits applied to medical and surgical benefits. For example, the group health plan or group health insurer could choose to impose a $1,000 annual deductible for medical and surgical benefits and a $500 annual deductible for mental health benefits.

The MHPAEA clearly recognizes that a group health plan or group health insurer may impose separate financial requirements or treatment limits to medical and surgical benefits and to mental health or substance use disorder benefits:

> (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
>
> (ii) 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 and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(29 U.S.C. §1185a(a)(3) and 42 U.S.C. §300gg-5(a)(3) as amended by Pub. Law No. 110-343, *emphasis added*).

The provisions state that a group health plan or group health insurer cannot impose "more restrictive" financial requirements or treatment limits for mental health or substance use disorder benefits. In addition, the MHPAEA states that if there is a financial requirement or treatment limit with respect to mental health or substance use disorder benefits, there must be a similar (or "more restrictive") requirement or limit for medical and surgical benefits (e.g., a plan cannot impose a $25 copayment for visits to a psychologist and not impose a copayment for a clinician providing medical or surgical services).[7]

In addition, permitting separate financial requirements or treatment limits for medical and surgical benefits and for mental health or substance use disorder services may allow patients to access mental health or substance use disorder benefits sooner in some cases. For example, a group health plan or group health insurer could choose to impose an

[7] The Office of Personnel Management has notified health insurance plans providing coverage through the Federal Employees Health Benefits (FEHB) program that separate financial requirements may be applied to medical/surgical benefits and to mental health and substance use disorders (although the OPM strongly encourages FEHB plans to offer combined deductibles). *See:* FEHB Program Carrier Letter 2009-08 (April 20, 2009).

overall $1,000 deductible and once the patient meets the deductible he or she may access any services covered by the health coverage or insurance. As an alternative, the group health plan or group health insurer could impose a $500 deductible for medical and surgical services and a separate $500 or lower deductible for mental health or substance use disorder services. In the latter case, a patient who needs to access mental health services will do so sooner because of the separate $500 deductible applied to those treatments.

Allowing separate financial requirements and treatment limits is also easier to administer for those group health plans and group health insurance issuers that choose to "carve out" mental health or substance use disorder services through a third-party vendor. Group health plans and health insurers may choose to carve-out these services because of the specialized expertise of the vendor in providing services for addressing behavioral health conditions or substance use disorders In many cases the third-party vendor does not coordinate the administration of health care claims with the medical and surgical benefits and, as a result, it would be very difficult to determine when a patient has met a "global" deductible or treatment limit applicable to medical and surgical benefits and mental health or substance use disorder benefits.

We believe that group health plans and group health insurance are permitted (but not required) to impose separate financial requirements and treatment limits with respect to medical and surgical benefits and for mental health or substance use disorder benefits.

AHIP recommends that guidance be provided to clarify that a group health plan or group health insurer may impose separate financial requirements and treatment limits with respect to medical and surgical benefits and for mental health or substance use disorder benefits.

Issue C2. Define the term "substantially all" for purposes of determining parity between medical and surgical benefits and mental health and substance use disorder benefits.

Discussion C2: As noted, the MHPAEA requires group health plans and group health insurers to determine parity by comparing financial requirements and treatment limitations applied to mental health or substance use disorder benefits to the "predominate" financial requirement or treatment limit "applied to substantially all medical and surgical benefits covered by the plan (or coverage . . . ." (29 U.S.C. §1185a(a)(5) and 42 U.S.C. §300gg-5(a)(5) as amended by Pub. Law No. 110-343).

The term "substantially all" is not defined in the MHPAEA. We believe there are different approaches that a group health plan or group health insurer could take to determine if a financial requirement or treatment limitation is "substantial" with respect to medical and surgical benefits including a calculation of the number (or dollar value) of claims or an actuarial value of the benefits to which a particular financial requirement or treatment limit are applied. We believe that group health plans and group health insurers may use any reasonable method to determine whether a financial requirement or treatment limitation is applicable to substantially all medical and surgical benefits.

AHIP recommends that guidance and regulations clarify that a group health plan or group health insurer may use any reasonable method to determine when a financial requirement or treatment limitation is applicable to substantially all medical and surgical benefits including an analysis of the number (or dollar value) or claims or the actuarial value of the benefits to which the financial requirements or treatment limits are applied.

Issue C3: Permit the determination of parity based on a comparison of inpatient services, outpatient services, in-network providers, and out-of-network providers.

Discussion C3: As discussed above, parity is determined under the MHPAEA on the basis of the "predominant" financial requirements or treatment limits applied to "substantially all medical and surgical benefits covered by the plan (or coverage) . . . ." Making such a determination depends on a variety of factors such as the different types of services or providers that are covered, the number of co-payment or co-insurance categories, and whether services are categorized as medical, surgical, mental health, or substance use disorder.

We believe it is appropriate to construct a general framework for making parity comparisons for financial requirements and treatment limits between different benefit categories. One comparison, involving in-network and out-of-network coverage, is explicitly recognized by the MHPAEA:

> In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(29 U.S.C. §1185a(a)(5) and 42 U.S.C. §300gg-5(a)(5) as amended by Pub. Law No. 110-343). This statutory language contemplates that the financial requirements and treatment limits applied to out-of-network medical and surgical benefits shall be consistent (i.e., at "parity") with out-of-network coverage for mental health or substance use disorder benefits.

We believe the same rule should be applied in comparing inpatient and outpatient benefits. The determination of parity should compare inpatient medical and surgical benefits with inpatient mental health and substance use disorder benefits. Likewise, the determination of parity with respect to outpatient medical and surgical benefits should be in comparison with the coverage for outpatient mental health or substance use disorder benefits.

AHIP recommends that guidance and regulations clarify that parity may based on a comparison of: (a) inpatient medical and surgical benefits to inpatient mental health and substance use disorder benefits; (b) outpatient medical and surgical benefits to outpatient mental health and substance use disorder benefits; (c) in-network medical and surgical benefits to in-network mental health and substance use disorder benefits; and (d) out-of-network medical and surgical benefits to out-of-network mental health and substance use disorder benefits.

Issue C4. Clarify that the MHPAEA does not mandate that group health plans and group health insurance cover any mental health conditions or substance use disorders, services, treatments or settings of care.

Discussion C4: The MHPAEA is intended to provide parity with respect to financial requirements and treatment limits. The new requirements do not mandate that group health plans or group health insurance provide coverage for any specific types of mental health conditions or substance use disorders, types of services or treatments, or settings of care.[8]

The MHPAEA addresses parity with respect to financial requirements and treatment limits. As noted above, "financial requirements" are defined as including "deductibles, copayments, coinsurance, and out-of-pocket expenses."

Treatment limits are defined as including "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." (29 U.S.C. §1185a(a)(3)(B) and 42 U.S.C. §300gg-5(a)(3)(B) as amended by Pub. Law No. 110-343, *emphasis added*). In this context, treatment limits applies to limits on the number of days of treatment or number of office visits that are covered (or similar limits) and is not intended to require the group health plan or group health insurer to cover all treatments or settings of care for a particular mental health condition or substance use disorder covered under the terms or conditions of the plan or benefits.

In addition, the MHPAEA makes clear that, except for the parity requirements, nothing in the Act is intended to affect "the terms and conditions of the plan or coverage relating to such benefits . . . ." (29 U.S.C. §1185a(b) and 42 U.S.C. §300gg-5(b) as amended by Pub. Law No. 110-343). The MHPAEA provisions indicate a clear understanding that group health plans and group health insurers may determine what conditions, treatments, services, or settings of care are covered under the terms and conditions of the plan or insurance policy.[9]

[8] As discussed above, there are requirements with respect to coverage for out-of-network services for mental health and substance use disorder benefits if the group health plan or group health insurer provides coverage for out-of-network medical and surgical services.

[9] As noted above and in Attachment 3, a significant number of states impose requirements for the coverage of mental health and substance use disorder services.

This position is supported by the legislative history of the MHPAEA. The Senate Committee Report includes the following statement with respect to the application of the parity requirements:

> The bill would not require plans to offer mental health benefits, nor would it require that those plans cover all types of mental health services or ailments if the plan covered any mental health services or ailments.

(Sen. Rep. No. 110-53, 110th Cong., 1st Session (2007) at p. 7). The House Energy and Commerce Committee Report includes similar language:

> In addition, this requirement does not change the current ability of an insurer or provider to determine medically necessary and appropriate care and treatment for their patients. It merely ensures that patients are not denied mental health coverage based on the specific disorder they have. For example, a person cannot be denied coverage by their health plan merely because they have autism. A plan may determine, however, whether a treatment is medically necessary or appropriate for a given person at a given time based on their individual situation.

(H. Rep. 110-374, Part 3, 110th Cong., 2nd Session (2008)).[10]

We believe the MHPAEA is not intended to require group health plans or group health insurance to cover any specific mental health condition or substance use disorder, services or treatments, or settings of care (other than the requirement to provide coverage for out-of-network benefits, discussed above).

AHIP recommends that guidance and regulations clarify that the MHPAEA does not impose any obligation on a group health plan or group health insurer to cover any specific mental health conditions or substance use disorders, services or treatments, or settings of care (except for out-of-network benefits in certain cases).

Issue C5: Clarify that treatment limitations subject to the MHPAEA do not include prior authorization, utilization review, or other processes used to provide appropriate medical management.

Discussion C5: As discussed, the MHPAEA requires group health plans and group health insurers to apply parity between medical and surgical benefits and mental health or substance use disorder benefits with respect to treatment limitations. Treatment limitations are defined as including "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits

[10] The version of H.R. 1424 approved by the Energy and Commerce Committee and discussed in the Committee Report included a requirement that group health plans and group health insurers cover all conditions in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This requirement was not included in the final version of the legislation.

on the scope or duration of treatment." (29 U.S.C. §1185a(a)(3)(B) and 42 U.S.C. §300gg-5(a)(3)(B) as amended by Pub. Law No. 110-343, *emphasis added*).

We believe treatment limitations do not include efforts by a group health plan or group health insurer to make decisions regarding coverage for appropriate care for an individual including utilization review, prior-authorization, and other medical management techniques. As used in the MHPAEA, treatment limitations only applies with respect to limits on days of coverage, or number of visits, or other "similar" limits.

AHIP recommends that guidance and regulations clarify that group health plans and group health insurers are permitted to use appropriate techniques to make decisions regarding coverage including utilization review, prior authorization, and other medical management.

Issue C6: Allow Medicaid managed care organizations (MCOs) to take into consideration whether there are additional "wrap-around" services provided by the state Medicaid program in the determination of parity with respect to treatment limits. Provide additional guidance to state Medicaid agencies on the application of the MHPAEA to Medicaid and CHIP MCOs.

Discussion C6: The MHPAEA applies to Medicaid MCOs if a State chooses to cover mental health or substance use disorder benefits through the Medicaid health plan. (*See*: 42 U.S.C. §1396u-2 (b)(8) and BBA State Managed Care Letter, January 20, 1998 from the Health Care Financing Administration). All states provide behavioral health services for Medicaid beneficiaries and most provide coverage for some substance use disorder benefits. States have taken a variety of approaches for such coverage -- the state Medicaid program may offer behavioral health benefits through a "carve-out" with a third-party vendor, contract with a MCO to provide some or all of the services, or give beneficiaries access to services through community mental health centers. In some cases the state will provide services directly or through the MCO based on the type of patient (e.g., "serious" behavioral health conditions are provided through state community health centers and the MCO provides all other mental health benefits).[11]

A unique situation has arisen in a handful of states where the Medicaid MCO is responsible for providing a set level of care – for example, up to 30 days for inpatient treatment for behavioral health conditions. After the 30 day treatment limit has been reached, the state Medicaid program agrees to cover any additional benefits needed by the beneficiary. In these cases the 30 day inpatient treatment limit through the MCO may be contrary to the MHPAEA unless there is a similar treatment limit under the MCO for medical and surgical services. However, the beneficiary will have access to additional in-patient services through the state Medicaid program.

[11] *See:* American Public Health Services Association and National Association of State Medicaid Directors, *Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety Net Primary Care Settings*, April 18, 2008, available at: http://www.aphsa.org/home/doc/IntegratedMentalHealthHRSA.pdf

We believe that Medicaid MCOs should be given the flexibility to structure the provision of mental health and substance use disorder benefits such that the determination of any treatment limits may take into account whether any additional services are available through the Medicaid program once such limits are reached.

In addition, Medicaid and CHIP MCOs have contracts with state Medicaid agencies which determine the benefits, operations, and process for each program and plans must wait for individual state implementation guidance on any changes to the financial requirements or treatment limitations. An MCO cannot unilaterally change the financial requirements or treatment limitations without a notification and approval from the state which may, in turn, be bound by legislative or regulatory requirements imposed on the program.

AHIP recommends CMS should provide guidance to clarify that a Medicaid MCO may take into consideration whether additional services are available to the beneficiary through the state when determining parity with respect to treatment limits applicable to mental health or substance use disorder services. In addition, CMS should provide guidance to state Medicaid programs regarding the application of the MHPAEA requirements to Medicaid and CHIP MCOs.

GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS SUBJECT TO THE MENTAL HEALTH PARITY ACT

Type of Product/Coverage	Subject to the Mental Health Parity Act?
ERISA Group Health Plans	**Yes**. *See*: 26 U.S.C. §9812, 29 U.S.C. §1185a, and 42 U.S.C. §300gg-5 as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343). Small employers (companies with 50 or fewer employees) are exempt.
Group Health Insurance	**Yes**. *See*: 26 U.S.C. §9812, 29 U.S.C. §1185a, and 42 U.S.C. §300gg-5 as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343). Small employers (companies with 50 or fewer employees) are exempt.
Individual Health Insurance	**No**. *See*: 26 U.S.C. §9812, 29 U.S.C. §1185a, and 42 U.S.C. §300gg-5 as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343).
Disability Income Insurance, Long-Term Care Insurance, Medicare Supplement Insurance, and Supplemental Insurance	**No.** Insurance that provides "excepted benefits" to group health plans are not subject to the Mental Health Parity Act of 1996 or the Mental Health Parity and Addiction Equity Act of 2008.. *See*: 26 U.S.C. §9832, 29 U.S.C. §1191h, and 42 U.S.C. §300gg-91.
Medicare Advantage Plans	The law applies to Medicare Advantage plans offered through an ERISA group health plan. See: 26 U.S.C. §9812, 29 U.S.C. §1185a, and 42 U.S.C. §300gg-5 as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343). Small employers (companies with 50 or fewer employees) are exempt.

Type of Product/Coverage	Subject to the Mental Health Parity Act?
	The law does not apply to a "stand-alone" Medicare Advantage plan. Retiree-only plans are not included in the definition of group health plans under ERISA. See: 26 U.S.C. §9831(a)(2), 29 U.S.C. § 1191a(a), and 42 U.S.C. §1191a.
Medicaid Health Plans	**Yes.** The law applies to Medicaid managed care plans, if a State chooses to cover mental health or substance use disorder benefits through the Medicaid health plan. *See*: 42 U.S.C. §1396u-2 (b)(8) and BBA State Managed Care Letter, January 20, 1998, Health Care Financing Administration.
State Children's Health Insurance Program	**Yes.** *See*: 42 U.S.C. §1397cc (f)(2) as amended by Section 582 of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. Law No. 111-3.
Federal Employees Health Benefits Plans	**Yes.** The Office of Personnel Management has imposed contracting requirements for FEHB that follow the Mental Health Parity Act of 1996and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. *See*: FEHB Program Carrier Letter No. 2000-17 (April 11, 2000), Program Carrier Letter No. 2008-17 (November 10, 2008), and Program Carrier Letter No. 2009-08 (April 20, 2009)..
State and Local Government Employee Plans	A self-funded non-federal governmental plan is subject to the Mental Health Parity Act unless the governmental plan chooses to be exempt from such requirements. A health insurance carrier that offers coverage to a non-federal governmental plan is subject to the Mental Health Parity Act unless. *See*: 42 U.S.C. §300gg-21 (b)(2)(A).

Attachment 2

FREQUENTLY ASKED QUESTIONS ABOUT THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

The "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" was signed into law on October 3, 2008 (Pub. L. No. 110-343). The Act amended the Mental Health Parity Act of 1996 and requires that certain group health plans and group health insurance apply the same treatment limits and financial requirements to medical and surgical benefits and to mental health and substance use disorder benefits.

The following "Frequently Asked Questions" (FAQs) provide an overview of the key provisions of this new law and the 1996 law. **As used in these FAQs the term "MHPA" applies to the Mental Health Parity Act of 1996 as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.**

1. What types of health coverage are subject to the MHPA?

The MHPA applies to certain group health plans and health insurance issuers that offer coverage in connection with a group health plan to the extent that such group health plans or health insurance issuers provide mental health and/or substance use disorder benefits. As discussed below, the MHPA may apply in certain situations to Medicare Advantage coverage offered through a group health plan, Medicaid and State Children's Health Insurance Programs (CHIP) coverage, and state and local government plans.

2. What types of benefits are subject to the parity requirements of the MHPA?

The MHPA applies to benefits with respect to services for mental health conditions and substance use disorders as defined under the terms of the plan or group health insurance coverage and in accordance with applicable Federal and State law.

3. Does the MHPA require group health plans or group health insurance to cover mental health or substance use disorder benefits?

No. The MHPA does not require group health plans or health insurance issuers to provide coverage for mental health or substance use disorder benefits. Health insurance issuers may, however, be subject to State laws that require the insurer to offer or provide coverage for mental health or substance use disorder benefits.

4. Does the MHPA require group health plans or group health insurance to provide any specific treatments, services or settings of care for a mental health condition or substance use disorder?

No. The MHPA requirement only applies to any mental health and/or substance use disorder benefits that may be offered by a group health plan or health insurance issuer. The MHPA does not require a group health plan or health insurance issuer to cover any specific treatments, services or settings of care for a covered mental health and/or substance use disorder benefit. See question No. 17 below regarding coverage for out-of-network providers.

5. Are all employers subject to the new law?

The MHPA does not apply to a "small employer." A small employer is defined in the MHPA as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employed at least 2 employees on the first day of the plan year. A small employer also includes an employer with one employee in states that apply group insurance laws to "groups of one."

6. How do you determine the size of an employer?

For purposes of determining whether an employer is a "small employer" the following rules apply:

(a) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. §414) are treated as one employer.

(b) If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a "small employer" is based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year.

(c) Any reference to an employer as a "small employer" includes a reference to a predecessor of the employer.

7. Are Medicaid managed care plans subject to the MHPA?

Yes. Medicaid managed care plans that offer mental health or substance use disorder benefits are required to comply with the MHPA insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage (*See*: 42 U.S.C. §1396u-2 (b)(8)). Medicaid managed care plans have contracts with state Medicaid agencies which determine the benefits, operations, and process for each program and plans must wait for individual state implementation guidance on any changes to the financial requirements or treatment limitations.

8. Does the MHPA apply to State Children's Health Insurance Programs (CHIP)?

Yes. A State Children's Health Insurance Program must comply with the MHPA insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage (*See:* 42 U.S.C. §1397cc (f)(2) as amended by Section 502 of the "Children's Health Insurance Program Reauthorization Act of 2009" (Pub. Law No. 111-3)). CHIP managed care plans have contracts with state Medicaid agencies which determine the benefits, operations, and process for each program and plans must wait for individual state implementation guidance on any changes to the financial requirements or treatment limitations.

9. Do Medicare Advantage plans have to comply with the MHPA?

The MHPA applies to coverage under a Medicare Advantage plan that is offered through a group health plan, provided that the plan is not offered by a small employer. The MHPA does not apply if the Medicare Advantage plan is offered through a separate group health plan that is offered only to retirees and that has fewer than 2 participants who are current employees (*See:* 26 U.S.C. §9831(a), 29 U.S.C. §1191a(a), and 42 U.S.C. §300gg-21(a)).

10. Does the law apply to health insurance sold in the individual market?

No. The MHPA does not apply to health insurance coverage sold in the individual market.

11. Does the MHPA apply to disability insurance, long-term care insurance, Medicare supplemental insurance, or other supplemental coverage?

No. Health insurance issuers that provide "excepted benefits" to group health plans (such as disability income insurance and long-term care and Medicare supplemental insurance coverage that is offered separately) are not subject to the MHPA (*See:* 26 U.S.C. §9832, 29 U.S.C. §1191b, and 42 U.S.C. §300gg-91).

12. Are self-funded non-federal governmental plans subject to the MHPA?

The MHPA applies to self-funded non-federal governmental plans unless they choose to be exempt from the MHPA (*see:* 42 U.S.C. §300gg-21 (b)(2)(A)). The MHPA does apply to health insurance coverage provided to a non-federal governmental plan.

13. How does the MHPA govern the provision of mental health or substance use disorder benefits?

In general, the MHPA requires group health plans and health insurance issuers that provide coverage to a group health plan to apply annual and lifetime dollar limits, financial requirements, and treatment limits for mental health or substance use disorder

benefits on the same or better basis as such requirements are applied to medical and surgical benefits.

14. How does the MHPA apply to annual and lifetime dollar limits?

A group health plan or group health insurance that provides coverage for medical and surgical benefits and mental health or substance use disorder benefits that includes an aggregate annual or lifetime dollar limit on substantially all medical and surgical benefits that may be paid under the plan or health insurance must either:

- not apply any annual or lifetime limits to any benefits;
- apply the same annual or lifetime dollar limits to the mental health benefits and/or substance use disorder benefits; or
- apply aggregate annual or lifetime dollar limits for mental medical and surgical benefits that are lower than the dollar limits applied to mental health or substance use disorder benefits.

Example 1

A group health plan that provides coverage for medical and surgical benefits and mental health or substance use disorder benefits is in compliance with the MHPA if it does any of the following:

- Does not have an aggregate annual dollar limit on any benefits.

- Has a $500,000 combined aggregate annual dollar limit on all benefits (medical/surgical, mental health, and substance use disorders).

- Has a $500,000 aggregate annual dollar limit for medical/surgical benefits, and a $500,000 or greater aggregate annual dollar limit (or no dollar limit) for mental health benefits and substance use disorder benefits.

Example 2

A group health plan that provides coverage for medical and surgical benefits and mental health or substance use disorder benefits on an inpatient and outpatient basis is in compliance with the MHPA if it does any of the following:

- Does not have an aggregate annual dollar limit on any benefits.

- Has a $500,000 combined aggregate annual dollar limit on all benefits provided on an outpatient basis (medical, surgical, mental health, and substance use disorders) and a $500,000 combined aggregate annual dollar limit on all benefits provided on an inpatient basis (medical, surgical, mental health, and substance use disorders).

- Has the following annual aggregate dollar limits:

    - $500,000 for inpatient medical and surgical benefits;
    - $500,000 for outpatient medical and surgical benefits;
    - $500,000 or greater limits (or no limits) for inpatient mental health and/or substance use disorder benefits; and
    - $500,000 or greater limits (or no limits) for outpatient mental health and/or substance use disorder benefits.

15. How does the MHPA apply to financial requirements?

The financial requirements applied to mental health or substance use disorder benefits must not be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits. In addition, a group health insurance plan or group health insurer may not apply a separate financial requirement to mental health or substance use disorder benefits that is not applicable to medical and surgical benefits.

Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket expenses but do not include annual or lifetime dollar limits. A financial requirement is "predominant" if it is the most common or frequent type of such requirement.

Example 1

A group health plan or group health insurance that provides coverage for medical and surgical benefits and mental health or substance use disorder benefits is in compliance with the MHPA if it does any of the following:

- Does not apply any copayment requirements.

- Applies a $20 copayment requirement for any patient visit to a health care provider regardless of the type of benefits (medical, surgical, mental health or substance use disorders).

- Applies a $20 copayment requirement for any patient visit to a health care provider in connection with a medical or surgical benefit and a $20 or lower copayment requirement (or no co-payment requirement) for any visit to a health care provider in connection with a mental health or substance use disorder benefit.

Example 2

A group health plan that provides coverage for medical and surgical benefits and mental health or substance use disorder benefits is in compliance with the MHPA if it does any of the following:

- Does not apply any annual deductible requirements for any benefits.

- Applies a $1,000 combined annual deductible applicable to all benefits (medical, surgical, mental health or substance use disorders).

- Applies a $1,000 annual deductible for medical and surgical benefits and a $1,000 or lower annual deductible (or no deductible) for mental health benefits or substance use disorder benefits.

Example 3

A group health plan that provides coverage for medical and surgical and mental health or substance use disorder benefits is in compliance with the MHPA if it does any of the following:

- Does not apply any annual coinsurance requirements.

- Applies an annual 5% coinsurance requirement to all benefits (medical, surgical, mental health or substance use disorders).

- Applies an annual 5% coinsurance requirement for medical and surgical benefits and a 5% or lower annual coinsurance requirement (or no coinsurance requirement) for mental health or substance use disorder benefits.

- Applies the following requirements:

    - 10% coinsurance for inpatient medical and surgical benefits;
    - 5% coinsurance for outpatient medical and surgical benefits;
    - 10% or lower coinsurance (or no coinsurance) for inpatient mental health or substance use disorder benefits; and
    - 5% or lower coinsurance (or no coinsurance) for outpatient mental health and substance use disorder benefits.

16. How does the MHPA apply to treatment limitations?

The treatment limitations applied to mental health or substance use disorder benefits must not be more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits. In addition, a group health plan or group health insurer may not apply a separate treatment limit to mental health or substance use disorder benefits that is not applicable to medical and surgical benefits.

"Treatment limitations" are defined as including limits on the frequency of treatment, number of visits, or days of coverage or other similar limits on the scope or duration of treatment. A treatment limit is "predominant" if it is the most common or frequent type of such limit.

Example 1

A group health plan that provides coverage for medical and surgical benefits and mental health or substance use disorder benefits is in compliance with the MHPA if it does any of the following:

- Does not apply annual limits on the number of treatments that are covered.

- Limits coverage on an annual basis to 30 visits to a health care provider regardless of the type of benefits (medical/surgical, mental health, or substance use disorders).

- Limits coverage on an annual basis to 30 visits to a health care provider in connection with a medical or surgical benefit and 20 or more visits (or no limits) to a health care provider in connection with mental health or substance use disorder benefits.

Example 2

A group health plan that provides coverage for mental health and substance use disorder benefits is in compliance with the MHPA if it does any of the following:

- Does not apply annual limits on the number of days that will be covered for inpatient treatment regardless of the type of benefits (medical, surgical, mental health or substance use disorders).

- Limits coverage to 50 days of inpatient treatment each year regardless of the type of benefits (medical, surgical, mental health or substance use disorders).

- Limits to 30 days each year for inpatient treatment in connection with a medical or surgical benefit and 30 or more days (or has no limits) for inpatient treatment in connection with mental health or substance use disorder benefits.

17. Does the MHPA require group health plans and group health insurance to cover out-of-network services?

Group health plans and group health insurance that covers out-of-network services for medical and surgical benefits must cover out-of-network services for mental health or substance use disorder benefits (if the group health plan or group health insurance otherwise covers mental health or substance use disorder benefits). The financial requirements or treatment limits applicable to out-of-network coverage for medical and surgical benefits are compared to the financial requirements or treatment limits applicable to out-of-network coverage for mental health and/or substance use disorder benefits.

Example 1

A group health plan or group health insurance that provides coverage for medical and surgical benefits and mental health or substance use disorder benefits is in compliance with the MHPA if it does any of the following:

- Requires patients to pay a $20 co-payment for any office visit to an in-network provider regardless of the type of benefit (medical, surgical, mental health or substance use disorder) and requires patients to pay 20% co-insurance for any services provided by an out-of-network provider regardless of the type of benefit (medical, surgical, mental health or substance use disorder).

- Does not apply any day treatment limits for network inpatient services but limits coverage on the number of days covered by an out-of-network inpatient facility regardless of the type of benefits (medical, surgical, mental health or substance use disorder).

- Limits treatments for an out-of-network medical or surgical in-patient facility to 20 days, limits treatments for an out-of-network mental health inpatient facility to 30 days, and does not apply any treatment limits for an out-of-network substance use disorder facility.

18. How does the cost exemption work?

Group health plans and group health insurers may be exempted from the mental health parity requirements under certain situations. This exemption only applies for subsequent plan years – in other words, the plan or insurer must comply with the parity requirements for at least one plan year and the exemption must be based on actual claims data.

A group health plan or group health insurer that demonstrate that the application of the parity requirements has increased the actual total costs of coverage for all benefits that are provided (medical/surgical, mental health, and substance use disorder) by more than 2% for the first plan year (1% for subsequent plan years) is exempted for the following plan year. The determination may be made based on actual claim costs incurred during the first six months of the plan year.

The determination of an increase in costs must be made in a written report by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. The group health plan or group health insurer must maintain the actuary's report and any underlying documentation for six years.

Plans or insurers claiming the increased cost exemption must notify the appropriate government agency and the plan participants and beneficiaries 30 days before the exemption becomes effective.

19. Does the MHPA prohibit group health plans or group health insurers from applying utilization review or medical necessity criteria or other policies to encourage appropriate and effective care?

The MHPA states that nothing in the Act, except for the requirement to provide parity in the application of financial and treatment limits or requirements, shall affect "the terms and conditions of the plan or coverage . . . ." As a result, group health plans and group health insurers are not restricted from applying utilization review, medical necessity determinations or other policies to encourage appropriate and effective care.

20. Are group health plans and group health insurers required to make information about their coverage for mental health or substance use disorder benefits available to enrollees or to health care providers?

Group health plans and group health insurers must provide the criteria used for medical necessity determinations applicable to coverage for mental health or substance use disorder benefits to any current or potential participant, beneficiary or contracting provider upon request. In addition, the plan or insurer must give participants and beneficiaries the reason for any denial of reimbursement or payment for mental health and substance use disorder benefits on request. Group health plans and group health insurers are required by existing rules under the Employee Retirement Income Security Act (ERISA) to provide such information as part of the Summary Plan Description given to participants and beneficiaries and in response to a denial of a claim for benefits.

21. Who is responsible for enforcing the requirements of the new law?

The Department of Labor is responsible for enforcing the provisions of the MHPA with respect to group health plans. The Department of Health and Human Services will enforce the requirements applicable to group health insurers. The Treasury Department enforces the Internal Revenue Code penalties for noncompliance.

22. What are the penalties for non-compliance with the MHPA?

In addition to any enforcement actions that may be taken under ERISA or the PHSA, a health insurance plan that violates the Act is subject to an excise tax of $100 per day for each day of noncompliance (*See:* 26 USC §4980D).

23. Does the Act preempt state laws?

In general, a group health plan and a health insurance issuer that provides coverage to a group health plan must comply with the MHPA. Health insurance issuers may also be subject to state laws that regulate or require insurers to offer or to cover mental health and/or substance use disorder benefits.

The MHPA preempts any state law that "prevents the application" of the Federal requirements (*See:* 29 U.S.C. §1191 (a)(1) and 42 U.S.C. §300gg-23 (a)(1)). In general,

this means that a state law is preempted if it is impossible for the health insurer to comply with both the state requirements and the MHPA.

The MHPA does not change the ERISA provisions that preempt any state laws that affect group health and welfare benefit plans (*See:* 29 U.S.C. §1191 (a)(2) and 42 U.S.C. §300gg-23 (a)(2)).

24. When do the provisions of the MHPA go into effect?

The requirements of the new law are effective for plan years beginning on or after one year from the date the legislation was signed into law (October 3, 2008). As a result, the provisions apply to new contracts and renewals on or after October 3, 2009.

In the case of group health plans maintained pursuant to one or more collective bargaining agreements, the MHPA is effective for plan years beginning after the latter of: (a) January 1, 2010 or (b) the date on which the last collective bargaining agreement relating to the plan terminates.[1]

[1] As noted, the effective date for collectively bargained plans was amended by Pub. L. No. 110-460.

Mental Health and Substance Abuse Coverage and Parity: Summary of Federal and State Requirements

(as of May 28, 2009)

History: In September 1996, Congress enacted legislation (P.L. 104-204), the Mental Health Parity Act (MHPA), requiring group health plans that offer mental health coverage benefits to apply the same aggregate lifetime dollar limits and annual dollar limits to mental health coverage as those applied to coverage of other services.

- Since the law was enacted, it continued to be reauthorized annually and was most recently reauthorized in 2007 until December 31, 2008.

- On October 3, 2008, Congress enacted the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008", otherwise known as the "Mental Health Parity Act" *(P.L. No. 110-343)*. Generally, this act requires group health plans and insurers to apply the same treatment and financial limits to medical and surgical benefits and to mental health and substance use disorder benefits.
  - These new requirements are effective October 3, 2009.
- On November 10, 2008 the Office of Personnel Management (OPM) issued a letter (No. 2008-17) explicitly applying the "Mental Health Parity Act" requirements to the Federal Employees Health Benefits Program (FEHBP). On April 20, 2009, OPM issued a subsequent letter (No. 2009-08) requiring all FEHBP carriers, starting January 1, 2010, to offer parity benefits for medical and surgical benefits and mental health or substance use benefits, including out-of-network benefits.

Approaches[1]: Forty-nine states (AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, and WI) have enacted mental health benefit mandate laws.

There are three basic approaches states have taken when enacting mental health or substance abuse coverage laws:

- benefits must be *covered;*
- benefits must be *offered*; and/or
- benefits must be covered on a *parity* basis with other medical, surgical, or physical illnesses.

- Some states combine these approaches and others use multiple approaches within the state (e.g. different requirements depending on group size, different requirements for state employee programs, etc).

Coverage Mandate: Thirty-eight states (AR, CA, CO, CT, HI, ID, IL, IA, KS, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, WA, WV, and WI) impose mandatory *coverage* requirements for mental health benefits.

[1] A state may appear in more than one category because several states have more than one mental health statute.

Mandated Offer: Thirteen states (AL, CA, CO, FL, GA, IL, KY, MS, MO, SC, TX, UT, and WA) impose *offering* requirements.

- Mandated offer requirements do not mandate coverage, but require that coverage be offered to the employer or individual, and, if those benefits are purchased, then they must be provided in a certain way.

Parity: Forty-two states (AK, AZ, AR, CA (parity with coverage for brain disorders), CO, CT, DE, GA, ID, IN, IL, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NH, NJ, NY, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, and WV) require *parity* between coverage of mental health and coverage for physical illnesses.

- Some states apply the requirement for parity only to annual and lifetime dollar limits, while others apply the parity requirement more broadly.

Definition of Mental Illness: Definitions of mental illness vary from state to state and some states provide different definitions within their own mental health laws.

- Seventeen states (AR, CT, FL, GA, HI, KS, KY, MO, NE, NH, NC, RI, SC, TN, UT, VT, and WA) define mental illness as any conditions defined in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the *International Classifications of Diseases* (ICD), and/or other standard nomenclature.
- Twenty-six states (AL, CA, CO, DE, HI, ID, IL, IA, LA, ME, MA, MO, MT, NE, NV, NH, NJ, NY, OH, OK, PA, SC, SD, TX, VA, and WV) define mental illness through a specified list of disorders (e.g., schizophrenia, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder).
- Eighteen states (AK, AZ, AR, CA, CO, MD, MI, MN, MS, MT, NJ, ND, OH, OR, TN, VA, WA, and WI) do not define the term "mental illness."
- Five states (IN, KS, NM, NY, and SC) define mental illness through reference to the definitions or other terms of the health benefit plan, contract, certificate, or policy documents.

Substance Abuse Benefits: Twenty-two states (AR, CT, FL, GA, HI, KS, KY, ME, MD, MA, MI, MN, MO, MT, NC, OR, RI, SC, UT, VT, VA, and WI) either explicitly include, or could be interpreted to include, coverage for substance abuse within their mental health laws.

- Twenty-nine states (AL, AK, AR, CA, CO, FL, GA, IL, KY, LA, ME, MA, MI, MN, MS, MO, NE, NV, NJ, NM, NC, ND, OH, PA, SD, TN, UT, WA and WV) have separate substance abuse coverage laws.

Exemption for cost increases: Fourteen states (AK, AZ, AR, IN, KS, MI, MS, MO, NV, NM, OH, OK, TN, and WV) contain provisions which provide an exemption from the mandated requirements if providing the coverage increases costs by a certain percentage.

- Five states (AL, ID, KY, NM, and NY) do not have a cost exemption, but require a study or report on the effectiveness of the mandated benefit, including the costs associated with providing coverage.

2009 legislative activity: To date, three states (AR, KS, and MT) enacted legislation expanding their current mental health law.

- AR amended its existing mental health parity law to, among other things, incorporate a specific reference to substance abuse disorders and to modify the cost exemption provisions.
- KS expanded its mental health coverage requirements to include drug abuse and substance abuse disorders.
- MT modified its severe mental illness coverage mandate to incorporate a coverage requirement for autism.

Chart: The following chart highlights key provisions of the federal mental health coverage law and catalogs current state mental health and substance abuse laws.

- This document does not include information on stand-alone state autism benefit mandates. For information on these state laws, please see the AHIP *Autism Spectrum Disorders: Summary of State Requirements* chart.

State law	Applicability	Definitions	Major provisions
Federal Law *29 USCA §§511, 512, and 712; 42 USCA §2705; and 26 USCA §9812 (P.L. No. 110-343)* Effective 10/3/09	Group health plans and group health insurers that provide coverage to group health plans; Medicaid health plans; and CHIP. Does not apply to insurers that provide "excepted benefits" to group health plans, such as disability income, long-term care, and Medicare supplemental coverage that is offered separately. Does not apply to small employers (2-50 employees), including companies in states that apply to "groups of one."	"*Mental health benefits"* means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable federal and state law. *"Substance use disorder benefits"* means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law. *"Financial requirement"* are defined as including deductibles, copayments, coinsurance, and out-of-pocket expenses. *"Treatment limitations"* are defined as including limits on the frequency of treatment, number of visits, or days of coverage or other similar limits on the scope or duration of treatment.	**Mental health and substance abuse parity requirements:** Does not mandate coverage of mental health or substance use disorder benefits. • Prohibits financial requirements applied to mental health or substance use disorder benefits from being more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits. **Scope of coverage:** To the extent an affected entity includes an aggregate annual or lifetime financial or treatment limit on substantially all medical and surgical benefits, requires the entity to apply the same applicable limits to mental health and substance use disorder benefits; or not include such limits for mental health or substance use disorders that are less than the limits applied to medical/surgical benefits. • Prohibits affected entities from applying a separate financial requirement to mental health or substance use disorder benefits that is not applicable to medical/surgical benefits. • Prohibits treatment limitations applied to mental health and substance use disorder benefits from being more restrictive than the predominate treatment limitations applied to substantially all medical/surgical benefits. • Prohibits affected entities from applying a separate treatment limit to mental health or substance use disorder benefits that is not applicable to medical/surgical benefits. **Benefit management:** Allows affected entities to apply utilization review, medical necessity determinations, or other tools to encourage appropriate and effective care. However, requires parity in the application of financial and treatment limitations or other requirements that affect the terms and conditions of the plan or coverage. • Requires affected entities to provide the criteria used for medical necessity determinations applicable to coverage for mental health or substance use disorder benefits to any current or potential participant, beneficiary, or contracting provider upon request. **Out-of-network services:** Requires the entity to provide out-of-network benefits for mental health and substance use disorders to the extent out-of-network coverage is provided for medical/surgical benefits. **Exemption for cost increases:** Exempts affected entities from the parity requirements, if after their initial year of complying with the law, they can demonstrate

State law	Applicability	Definitions	Major provisions
			that the application of the parity requirements has increased the actual total costs of coverage for medical/surgical benefits and mental health and/or substance uses disorder benefits by more than 2% for the first plan year and 1% for subsequent plan years. • Requires the determination of an increase in cost to be a written report by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. • Requires affected entities to promptly notify the Secretary of Labor or HHS (depending on agency oversight) and any appropriate state agencies, as well as all participants and beneficiaries of its exemption. **Penalties:** Imposes an excise tax of $100/per day for each day of noncompliance. **Preemption:** Follows the HIPPA standard for preemption – preempting any state law that "prevents the application of" the federal requirements, thus preempting state law if the health insurer is unable to comply with both the applicable state law and the federal parity requirements.
Alabama *Ala. Code §27-20A-1, et. seq.* Effective 1979	Group, blanket, franchise or association health insurance policies providing coverage on an expense incurred basis; group, blanket, franchise or association service or indemnity contracts issued by nonprofit corporations; group-type self insurance plans; and HMOs.	*"Alcoholism"* means a chronic disorder or illness in which the individual is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, injury to health and effective functioning.	**Substance abuse mandated offer requirements:** Requires affected entities offering alcoholism treatment to provide benefits to any insured for expenses incurred in connection with the treatment of alcoholism when such treatment is prescribed by a licensed doctor. **Scope of coverage:** Requires benefits offered to include inpatient, outpatient, or residential treatment rendered at a state licensed hospital or at a licensed short-term residential alcoholism treatment or detoxification facility. • Requires benefits to include a minimum of 30 days of inpatient treatment or its equivalent per calendar year. • Uses a formula to compute equivalency which equates 2 days of treatment in a short-term residential alcoholism treatment facility to 1 day of inpatient treatment and which equates 3 sessions of outpatient treatment by a licensed doctor or an alcoholism treatment facility to 1 day of inpatient treatment.
Alabama *Ala. Code §27-54.1, et. seq.*	Group health benefit plans. Does not apply to plans	*"Mental illness"* means the following: • schizophrenia; • schizophrenia form disorder;	**Mental health mandated offer requirements:** Requires affected entities to offer benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

State law	Applicability	Definitions	Major provisions
Effective 2001	covering employers with 50 or fewer employees.	• schizoaffective disorder; • bipolar disorder; • panic disorder; • obsessive-compulsive disorder; • major depressive disorder; • anxiety disorders; • mood disorders; and • any condition or disorder involving mental illness, excluding alcohol and substance abuse, that falls under any of the ICD diagnostic categories.	• Requires affected entities to offer to provide, at a minimum, inpatient, day treatment, and outpatient services for a person suffering from a mental or nervous condition. **Scope of coverage:** Permits affected entities to include provisions in their contracts for maximum benefits and coinsurance and limitations, deductibles, exclusions, and utilization review consistent with state law. • Requires reasonable efforts to be made to include a sufficient number of qualified providers to insure reasonable access to services. **Benefit management:** Requires, at the request of the plan, a mental health provider to furnish data substantiating that initial or continued treatment is medically necessary and appropriate. • Requires the insurer or other issuer of the group health benefit plan to use the same criteria for medical treatment of mental illness as for medical treatment for physical illness under the same contract when making a medical necessity determination. • Clarifies that affected entities may continue to establish and apply selection criteria and utilization protocols for mental health providers, including the designation of types of providers for which coverage is provided as well as credentialing criteria used in the selection of providers. **Out-of-network services:** Does not require coverage of services of providers who are not covered or participating in an affected entity's network. **Cost report:** Requires affected entities to provide an annual cost report to the Insurance Commissioner. • Requires such report to include certification of parity in mental health benefits and total annual costs of mental health services relative to total health costs. • Requires the Commissioner to compile this data for all health benefit plans in an annual report solely for the purpose of demonstrating the health cost impact of these requirements. **Rules of construction:** Provides that the requirements shall not be construed to require coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness.
Alaska	Health care insurance	"*Large employer*" means an em-	**Mental health parity requirements:** Does not mandate coverage mental health

State law	Applicability	Definitions	Major provisions
Alaska Stat. §§21.54.151 and 21.54.500 Effective 2006	plans providing medical/surgical and mental health benefits sold to large employers.	ployer that employed an average of at least 51 employees on the business days during the preceding calendar year and that employs at least 2 employees on the first day of a health benefit plan year.	illness or conditions. • Prohibits financial requirements applied to mental health benefits from being more restrictive than those applied to medical/surgical benefits. **Scope of coverage:** Prohibits plans that do not include an aggregate lifetime and/or annual limit on substantially all medical/surgical benefits from imposing an aggregate lifetime or annual limit on mental health benefits. • Requires plans that include an aggregate lifetime and/or annual limit on substantially all medical/surgical benefits to: ▪ include the mental health benefits within the aggregate lifetime and/or annual limit without distinguishing between the limit for medical/surgical benefits and mental health benefits; or ▪ provide an aggregate lifetime and/or annual limit for mental health benefits that is not less than the limit for medical/surgical benefits. • Requires plans that include different aggregate lifetime limits or none on different categories of medical/surgical benefits to provide for aggregate lifetime limits on mental health benefits consistent with federal law. • Requires plans that include different annual limits or none on different categories of medical/surgical benefits to provide for annual limits on mental health benefits consistent with federal law. **Benefit management:** Does not affect the terms and conditions relating to the amount, duration, or scope of mental health benefits under a plan that provides mental health benefits, including cost sharing, limits on the number of visits or days of coverage, and requirements relating to medical necessity. **Exemption for cost increases:** Exempts a plan from the parity requirements if the application such requirements would result in an increase in the cost under the plan of at least 1%.
Alaska *Alaska Stat. §21.42.365* Effective 1997	Health care insurers. Does not apply to insurers providing coverage for less than five employees or fraternal benefit societies.	*"Alcoholism or drug abuse"* means an illness characterized by: • a physiological or psychological dependency, or both, on alcoholic beverages of controlled substances; or • habitual lack of self-control in using alcoholic beverages	**Substance abuse coverage requirements:** Requires affected entities offering a health care insurance plan (except for catastrophic insurance) to provide coverage for treatment of alcoholism or drug abuse. • Requires insurers to offer benefits to employers with 20 or less employees. **Scope of coverage:** Requires benefits to be at least $9,600 over 2 consecutive benefit years and include lifetime benefits of at least $19,200 and adjustments to these amounts every 3 years consistent with CPI.

State law	Applicability	Definitions	Major provisions
		or controlled substances to the extent that the person's health is substantially impaired or the person's social or economic function is substantially disrupted.	• Prohibits affected entities from: ▪ requiring different deductibles and co-pays for alcoholism or drug abuse than for another covered illness; ▪ using a different claim payment methodology in determining benefits for alcoholism or drug abuse than that used in determining the benefits for another covered illness; ▪ requiring different pre-notification of treatment or a second opinion for alcoholism and drug abuse than for other covered illnesses; ▪ limiting coverage with provisions not applicable to other covered illnesses, including pre-existing illnesses; ▪ limiting treatment to either an inpatient or outpatient service; ▪ excluding from coverage the cost of medically necessary treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or ▪ denying reimbursement for actual services rendered solely because treatment was interrupted or not completed.
Arizona *Ariz. Rev. Stat. §20-2322* Effective 1998	Group health plans and issuers. Does not apply to small employers (2-50 employees).	No definitions. However, stipulates that mental health services or mental health benefits do not include benefits for the treatment of substance abuse or chemical dependency.	**Mental health parity requirements:** Does not mandate coverage mental health illness or conditions. However, to the extent benefits are provided, they must comply with the below requirements. **Scope of coverage**: Prohibits affected entities that provide coverage for mental health benefits from imposing different aggregate annual or aggregate lifetime dollar limits for mental health benefits than for medical/surgical benefits. • Requires a plan's aggregate annual or aggregate lifetime limit to be applicable to both medical/surgical benefits and mental health benefits. **Benefit management:** Permits affected entities providing mental health benefits to impose terms and conditions in relation to the amount, duration, or scope of coverage for such services or benefits under the plan, including: cost-sharing provisions; limits on the number of visits or days of coverage; and requirements relating to medical necessity. **Exemption for cost increases:** Relieves a plan of compliance if the provision of these services and benefits increases costs to the plan by at least 1%.

State law	Applicability	Definitions	Major provisions
Arkansas *Ark. Code Ann. §23-86-113* Effective 1983	Blanket and group accident and health policies and contracts of hospital and medical service corporations.	No definitions.	**Mental health coverage requirements:** Requires affected entities providing hospitalization or medical benefits to provide inpatient, outpatient, and partial hospitalization for mental illness. • Requires affected entities providing mental health coverage to offer coverage for the payment of services rendered by licensed professional counselors. ▪ If the offer is accepted, provides that the amount paid will be subject to the same limits in the policy for mental health coverage. **Scope of coverage:** Permits affected entities to establish a co-pay of up to 20% for inpatient, partial hospitalization, or outpatient care, even if the requirement is different from the co-pay for any other covered condition or illness. • Prohibits affected entities from imposing limits on benefits to deductible amounts, lifetime maximum payments, payments for outpatient visits, or payments per day of partial hospitalization which differ from benefits for other conditions or illnesses. • Requires policies to small employers (50 employees or less) to impose an annual maximum benefit payable of no less than $7,500 per calendar year. • Permits policies sold to employers with 51 or more employees to impose an annual maximum of 8 inpatient or partial hospitalization days and 40 outpatient visits.
Arkansas *Ark. Code Ann. §23-79-139* Effective 1987	Insurers, hospital and medical service corporations, and HMOs. Applies to group policies or contracts. Does not apply to: • blanket short-term travel accident only; • limited or specified disease; • conversion policies or contracts; and/or • Medicare supplement policies.	*"Alcohol or drug dependency"* means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.	**Substance abuse mandated offer requirements:** Requires affected entities to offer and make available benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors. • Allows the policy or contract holder to reject the coverage or select any alternative level of benefits. **Scope of coverage:** Requires any benefits provided under alcohol or drug dependency coverage to be determined "necessary care and treatment" in an alcohol or drug dependency treatment facility and in a hospital. • Requires policies that provides alcohol or drug dependency treatment and total annual benefits for all illnesses in excess of $6,000 to provide: ▪ for each 24-month period, a minimum benefit of $6,000 for the "necessary care and treatment" of alcohol or drug dependency; ▪ a lifetime minimum benefit of $12,000 for "necessary care and treatment" of alcohol or drug dependency; and

State law	Applicability	Definitions	Major provisions
			▪ no more than one-half of the policy's maximum benefits for alcohol or drug dependency for a 24-month period for the "necessary care and treatment" of alcohol or drug dependency in any 30 consecutive day period.
Arkansas *Ark. Code Ann. §23-99-501, et. seq. [as amended by H.B. 2195 (2009)]* Effective 1997 Amended 2009	Health benefit plans and health care insurers, including those providing benefits to state and public school employees. Does not apply to: • dental, vision, specified disease, accidental injury, long term care, disability income, or Medicare supplement plans; • state workers' compensation plans; • individual health benefit plans (if individuals who satisfy the insurer's underwriting standards are offered the option to purchase a plan that includes the mandated coverage); or small employer (fewer than 50 employees) health benefit plans (if the insurer offers a plan that includes	*"Mental illness"* and *"substance use disorders"* means those illnesses and disorders that are covered by a health benefit plan listed in the International Classification of Diseases Manual (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM). • Unless specifically otherwise stated, "mental illness" includes substance use disorders.	**Mental health and substance abuse parity requirements:** Requires affected entities that provide coverage for a mental illnesses or substance abuse disorder to provide coverage for the treatment of the mental illness or substance abuse disorder on a parity basis with other medical illnesses. **Scope of coverage:** Prohibits any differences in the health benefit plan for the treatment of mental illnesses and substance abuse disorders with respect to the duration or frequency of coverage, the dollar amount of coverage, or financial requirements from those of other illnesses. • Permits affected entities to: ▪ negotiate separate reimbursement rates and service delivery systems, including, without limitation carve-out arrangements; ▪ manage the provision of benefits for mental illnesses by common methods used for other medical conditions, including without limitation: pre-admission screening, prior authorization, or other mechanisms designed to limit coverage of services for mental illnesses to those that are deemed medically necessary; ▪ limit coverage to covered services authorized by the health benefit plan if the limitations are consistent with state law; ▪ use separate but equal cost-sharing features for mental illnesses or developmental disorders; and ▪ use a single lifetime or annual dollar limit as applicable to other medical illnesses. • Permits affected entities to provide coverage for a service that is generally not used for other injuries, illnesses, and conditions (e.g., intensive case management, community residential treatment programs, or social rehabilitative programs), as long as all other requirements of state law are met. • Permits affected entities to provide coverage for a service, including without limitation physical rehabilitation or durable medical equipment, which generally is not used in the diagnosis or treatment of serious mental illness, but is used for other injuries, illnesses, and conditions, as long as all other requirements of state law are met. **Benefit management:** Requires the health benefit plan to make available the med-

State law	Applicability	Definitions	Major provisions
	the mandated coverage).		ical necessity criteria for mental illnesses to any current or potential covered individual or contracting provider upon request. • On request, requires the reason for the denial of reimbursement or payment to be made available to a covered individual. • Permits affected entities to utilize common utilization management protocols, including without limitation preadmission screening, prior authorization of service, or other mechanisms designed to limit coverage to medically necessary services although the protocols are not used in conjunction with other illnesses or conditions covered by the plan. **Out-of-network services:** Requires a health benefit plan that provides coverage for medical benefits provided by out-of-network providers to provide coverage for mental illness services provided by out-of-network providers (if the plan provides both medical and mental illness benefits). **Exemption for cost increases:** Exempts a health benefit plan from the parity requirements if the plan demonstrates that the coverage mandate resulted in an increase in the actual costs of coverage with respect to medical and surgical benefits and mental illness benefits by an amount that exceeds 2% for the first plan year, or 1% for each subsequent plan year. • Applies the exemption for a period of 1 year. • Requires the exemption/cost determination to be made in writing and certified by a qualified and licensed actuary who is a member in good standing with the American Academy of Actuaries. • To obtain an exemption, requires affected entities to make the increased cost determination required after it has complied with the requirements of the law for the first 6 months of the plan year. • Requires an insurer electing to claim an exemption to notify the Insurance Commissioner, the policyholder or contract holder, and the certificate holders, subscribers, and enrollees covered by the plan. • Requires the notification to the Commissioner include: ▪ a description of the number of covered lives under the health benefit plan at the time of the notification, and if applicable, at the time of any prior election of the increased cost exemption; and ▪ for the current and previous health benefit plan years (i) a description of the actual total costs of coverage for medical and surgical benefits and mental illness benefits under the health benefit plan, and (ii) the actual total costs of coverage with respect to mental illness benefits under the health benefit plan.

State law	Applicability	Definitions	Major provisions
			▪ Deems the notifications to the Commissioner to be confidential and requires the Commissioner to make available, upon request but no more than annually, an anonymous itemization of notifications that includes a summary of the data received. **Rules of construction:** Provides that nothing in the requirements shall be construed to: • require equal coverage between treatments for mental illness and coverage for preventive care; or • include a Medicare or Medicaid plan or contract, or any privatized risk or demonstration program for Medicare or Medicaid coverage.
California *Cal. Ins. Code §10125* Effective 1974	Insurers issuing group disability insurance[2] which covers hospital, medical, or surgical expenses.	No definitions.	**Mental health mandated offer requirements:** Requires affected entities to offer coverage for expenses incurred as a result of mental or nervous disorders, under terms and conditions agreed upon between the group policyholder and the insurer. • Requires affected entities to communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating. **Scope of coverage:** If the terms and conditions include coverage for inpatient care for nervous or mental disorders, requires the coverage to extend to treatment in general acute care hospitals, acute psychiatric hospitals, and psychiatric health facilities. **Benefit management:** Permits affected entities to negotiate and enter into a contract with a professional or institutional provider for alternative rates of payment.
California *Cal. Ins. Code §10123.6* Effective 1985	Insurers issuing group disability insurance which covers hospital, medical, or surgical expenses.	No definitions.	**Substance abuse mandated offer requirements:** Requires affected entities to offer coverage for the treatment of alcoholism under terms and conditions agreed upon between the group policyholder and the insurer. • Requires affected entities to communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.

[2] In California, health insurance is known as "disability insurance." For more information, see AHIP's *Disability Income Protection and Health Insurance: State Definitions* chart.

State law	Applicability	Definitions	Major provisions
			Scope of coverage: Provides that if the group subscriber or policyholder agrees to such coverage or to coverage for treatment of chemical dependency, or nicotine use, the treatment may take place in facilities licensed to provide alcoholism or chemical dependency services. **Benefit management:** Allows a policy to subject treatment for nicotine abuse to separate deductibles, co-pays, and overall cost limitations.
California *Cal. Ins. Code §10123.15* Effective 1989	Group policies of disability insurance which covers hospital, medical, and surgical expenses, and which offer coverage for disorders of the brain.	*"Biologically based severe mental disorders"* includes: • schizophrenia; • schizo-effective disorder; • bipolar disorders; • delusional depressions; and • pervasive developmental disorder.	**Mental health mandated offer requirements:** Requires affected entities to offer coverage for the treatment of biologically based severe mental disorders in the same manner as for other disorders. **Scope of coverage:** Requires coverage to be subject to the same terms and conditions applied to the treatment of other disorders of the brain. **Benefit management:** Permits affected entities to reserve the right to confirm diagnoses and to review the appropriateness of specific treatment plans as necessary to ensure that coverage is provided for only those diagnostic and treatment services which are medically necessary.
California *Cal Health & Safety Code §1374.72* Effective 2000	Health care service plans (HMOs) and insurers issuing disability insurance policies. Does not apply to the Medi-Cal program.	*"Severe mental illness"* includes: • schizophrenia; • schizo-affective disorder; • bipolar disorder (manic depressive illness); • major depressive disorders; • panic disorder; • obsessive-compulsive disorder; • pervasive developmental disorders or autism; and • anorexia nervosa and bulimia nervosa. A child suffering from a "se*rious emotional disturbances of a child"* includes a child who:	**Mental health coverage requirements:** Requires affected entities that provide coverage for medical/surgical treatment to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and for serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions. **Scope of coverage:** Requires the terms and conditions on maximum lifetime benefits, co-pays, and individual and family deductibles to be the same for mental health coverage as for medical/surgical coverage. • Requires benefits to include outpatient services, inpatient hospital services, partial hospitalization services, and prescription drugs (if the plan includes coverage for prescription drugs). **Benefit management:** Allows an insurer to use case management, network providers, utilization review, prior authorization, co-pays, or other cost-sharing arrangements. • Permits coverage to be administered through a separate specialized health care

State law	Applicability	Definitions	Major provisions
		• has one or more mental disorders as defined in the most recent DSM, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and • meets specified criteria of §5600.3 of the Welfare and Institutions Code (requires substantial interference activities of daily living.)	service plan or mental health plan, without requiring any additional license. • Permits affected entities providing benefits through a PPO to require enrollees residing in the geographic area served by a specialized health care service plan to secure mental health services in that area.
California *Cal. Family Code §1373 and Cal. Health &Safety Code §§1250 and 1250.2* Effective 2008, 1973 and 1978 Amended N/A, 2005, and 1997	Health care service plans (HMOs) or specialized health care service plans	"*Acute psychiatric hospital"* means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for mentally disordered, incompetent, or other patients referred to in Division 5 (commencing with §5000) or Division 6 (commencing with §6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. "*Psychiatric health facility*" defined to mean a health facility, licensed by the State Department of Mental Health, that provides 24-hour inpatient care for mentally disordered, incompetent, or	**Mental health coverage requirements:** Permits affected entities to provide for coverage of, or for payment for, professional mental health services or for the exclusion of these services. • Requires a health care service plan that offers outpatient mental health services but does not cover these services in all of its group contracts to communicate to prospective group contract holders as to the availability of outpatient coverage for the treatment of mental or nervous disorders. **Scope of coverage:** If the terms and conditions include coverage for services provided in a general acute care hospital or an acute psychiatric hospital and do not restrict or modify the choice of providers, requires the coverage to extend to care provided by a psychiatric health facility. • Prohibits a plan from prohibiting the member from selecting any licensed psychologist; any marriage and family therapist, or licensed clinical social worker licensed; any licensed registered nurse who has a master's degree in psychiatric-mental health nursing; or any advanced practice registered nurse certified as a clinical nurse specialist who participates in expert clinical practice in the specialty of psychiatric-mental health nursing; to perform the particular services covered under the terms of the plan, and the health care professional is expressly authorized by law to perform these services. • Requires a plan contract that provides benefits that accrue after a certain time of confinement in a health care facility to specify what constitutes a day of confinement or the number of consecutive hours of confinement that are requi-

State law	Applicability	Definitions	Major provisions
		other persons described in Division 5 (commencing with §5000) or Division 6 (commencing with §6000) of the Welfare and Institutions Code.	site to the commencement of benefits. **Benefit management:** Nothing shall be construed to allow a member to select and obtain mental health or psychological services from a health care professional who is not directly affiliated with or under contract to the health care service plan or specialized health care service plan to which the member belongs.
Colorado *Colo. Rev. Stat. §10-16-104(5)* Effective 1992 Amended 2005	Group policies or contracts providing hospitalization or medical benefits.	Does not define *"mental illness"* but states that it does not include autism.	**Mental health parity requirements:** Requires affected entities to provide benefits for conditions arising from mental illness equal to the below noted requirements. • Prohibits affected entities from establishing deductibles for mental illness that differ from those for other conditions or illnesses. **Scope of coverage:** In the case of basic coverage benefits, requires coverage of 45 days for inpatient care or 90 days for partial hospitalization in any 12-month benefit period and provides a formula for calculating exchange of partial hospitalization from inpatient days on a 2:1 basis. • In the case of major medical coverage, requires coverage of at least $1,000 in any 12-month period or 20 visits per year for outpatient services when services are provided by certain licensed entities or professionals. • Allows affected entities to establish co-pay or coinsurance requirements for mental illness which differ from co-pays or coinsurance for other conditions or illnesses, provided that the co-pay and coinsurance do not exceed 50%. • Permits the Insurance Commissioner to exempt any policy or type of policy with respect to which the commissioner has determined that the prescribed mental illness benefits are inapplicable or inappropriate. **Benefit management:** Permits affected entities to limit coverage to services that are rendered by a provider who is designated by and affiliated with the HMO.
Colorado *Colo. Rev. Stat. §10-16-104 (5.5)* Effective 1998 Amended 2007	Group health care service policies and contracts. Does not apply to dental, vision, Medicare supplement, long term care, home health,	*"Biologically based metal illness"* means: • schizophrenia; • schizo-affective disorder; • bipolar affective disorder; • major depressive disorder; • specific obsessive-compulsive disorder; and	**Mental health parity requirements:** Requires affected entities to provide coverage for the treatment of biologically based mental illness that is no less extensive than the coverage provided for any other physical illness, including any pre-authorization or utilization review mechanisms. • Requires all affected entities to provide coverage for the treatment of mental disorders that is no less extensive than the coverage provided for a physical illness. • Permits different mechanisms for pre-authorization or utilization review be-

State law	Applicability	Definitions	Major provisions
	community based care, disability income, and specified disease policies or contracts.	• panic disorder. *"Mental disorder"* means • posttraumatic stress disorder; • drug and alcohol disorders; • dysthymia; • cyclothymia; • social phobia; • agoraphobia with panic disorder; and • general anxiety disorder. The term includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, day treatment and in-patient basis, exclusive of residential treatment.	tween medical specialties to the extent they are not more restrictive with respect to a covered person or a mental health provider than for any other physical illness. **Scope of coverage:** Provides that the benefits need not be provided to the extent that such benefits duplicate benefits provided under Colo. Rev. Stat. §10-16-104.5, which requires parity of coverage for autism if autism is covered under the policy. **Benefit management:** Permits affected entities to use utilization review mechanisms in determining whether to provide coverage for drug and alcohol disorders and eating disorders even if the carrier does not use utilization review mechanisms in determining whether to provide coverage for a physical illness. • Permits affected entities to limit coverage to services that are rendered by a provider who is designated by and affiliated with the HMO.
Colorado *Colo. Rev. Stat. §10-16-104 (9)* Effective 1995	Insurers.	No definitions.	**Substance abuse mandated offer requirements:** Requires insurers to offer coverage for the treatment of conditions arising from alcoholism. **Scope of coverage:** Requires coverage to include 45 days of inpatient treatment annually and outpatient benefits of $500 annually. • Permits insurers to establish co-pays for substance abuse that are different from other conditions or illnesses; however, prohibits affected entities from establishing at co-pay that exceeds 50% for substance abuse. • Permits insurers to establish deductibles for such benefits on the same basis as for any other condition or illness. • Prohibits benefits from being payable unless the patient has completed the full continuum of care, including detoxification and rehabilitation.
Connecticut *Conn. Gen. Stat. §38a-514* Effective 2000	Individual and group health insurance policies.	*"Mental and nervous conditions"* mean mental disorders, as defined in the most recent edition of the DSM. • The term appears to include	**Mental health coverage requirements:** Requires health policies to provide benefits for the diagnosis and treatment of mental or nervous conditions. • Prohibits such policies from establishing any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of a mental or nervous condition than for the diagnosis or treatment of a

State law	Applicability	Definitions	Major provisions
		alcoholism and drug addiction. • The term does not include mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorder, relational problems, and additional conditions that may be a focus of clinical attention that are not otherwise defined as mental disorders in the most recent DSM.	medical/surgical condition. **Scope of coverage:** Permits benefits to be provided by licensed physicians, psychologists, social workers, and marital and family therapists. • Requires, in the case of benefits based upon confinement in a residential treatment facility, benefits to be payable only in situations in which: ▪ the insured has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior; ▪ the insured has been confided in a hospital for such illness for a period of at least three days immediately preceding such confinement in a residential treatment facility; and ▪ such illness would otherwise necessitate continued confinement in a hospital if such care and treatment were not available through a residential treatment center for children and adolescents. • Requires services rendered for confinement in a residential treatment facility to be based on an individual treatment plan. **Rule of construction:** Permits affected entities to exclude such benefits if the benefits are included in a separate policy issued to the same group.
Connecticut *Conn. Gen. Stat. §38a-553* Effective 2001	Individual and group heath care plans.	*"Mental conditions"* is defined under §38a-514 (see above.)	**Mental health coverage requirements:** Requires affected entities to include minimum standard benefits including the diagnosis or treatment of mental conditions in accordance with requirements established under §38a-514 (see above). **Scope of coverage:** Prohibits the application of deductibles for the diagnosis or treatment of mental and nervous conditions that exceeds a maximum limit of $1,000 per covered individual, or $2,000 per covered family, with such limits being adjusted annually consistent with the CPI. • Permits covered expenses incurred after the applicable deductible has been reached to be paid at a rate of 50%.

State law	Applicability	Definitions	Major provisions
Delaware *Del. Code Ann. §18.35.3577* Effective 1999	Carriers that provide health insurance and health benefit plans. Does not apply to accident-only, credit, dental, vision, Medicaid, long-term care, disability income, specified disease, hospital confinement indemnity, or limited health benefit coverages.	*"Serious mental illness"* means any of the following biologically based mental illnesses as defined in the most recent edition of the DSM: • schizophrenia; • bipolar disorder; • obsessive-compulsive disorder; • major depressive disorder; • panic disorder; • anorexia and bulimia nervosa; • schizo-affective disorder; or • delusional disorder. The term does not include alcoholism or other drug dependencies.	**Mental health parity requirements:** Requires affected entities to provide coverage of serious mental illness that place no greater financial burden on an insured for covered services than for the diagnosis and treatment of any other illness or disease covered by the health benefit plan. **Scope of coverage:** Permits affected entities to limit coverage to services: ▪ rendered by a licensed mental health professional; ▪ found to be medically necessary; and ▪ received in compliance with the policy's administrative requirements. • Permits affected entities to further condition coverage of services of a serious mental illness in the same manner and to the same extent as coverage for all other illnesses and diseases or conditions, including pre-certification and referral requirements. **Benefit management:** Permits a carrier to, directly or by contract with another qualified entity, manage the mental health benefit in order to limit coverage of services provided in the diagnosis and treatment of a serious mental illness to those services that are deemed medically necessary. • Permits the management of benefits for serious mental illnesses by methods used for the management of benefits provided for other medical conditions, or by management methods unique to mental health benefits. ▪ Such methods may include, pre-admission screening, prior authorization, utilization review, and the development and monitoring of treatment plans. ▪ Permits affected entities to further condition coverage of services of a serious mental illness in the same manner and to the same extent as coverage for all other illnesses and diseases or conditions, including precertification and referral requirements. • Provides that the ability to manage benefit shall not be construed to require a carrier to employ the same benefit management procedures for serious mental illnesses that are employed for the management of other illnesses or diseases covered by the health benefit plan or to require parity or equivalence in the rate, or dollar value, of claims denied. **Out-of-network services:** Permits a health benefit plan using a provider network to exclude the required coverage for out-of-network services.
Florida	Group insurers, HMOs,	*"Mental and nervous disorders"*	**Mental health mandated offer requirements:** Requires affected entities to offer

State law	Applicability	Definitions	Major provisions
Fla. Stat. ch. §37.627.668 Effective 1992	and nonprofit hospital and medical service plan corporations.	means those mental and nervous disorders as defined in the standard nomenclature of the American Psychiatric Association.	benefits for the necessary care and treatment of mental and nervous disorders. **Scope of coverage:** Requires such benefits to include inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors that are not less favorable than for physical illnesses generally, except that: ▪ inpatient benefits may not be less than 30 days annually; ▪ outpatient benefits may not be less than $1,000 annually; and ▪ partial hospitalization must be provided under direction of licensed physician. • Permits affected entities to apply different durational limits, dollar amounts, and coinsurance factors for physical illnesses if benefits exceed the inpatient and outpatient limitations.
Florida *Fla. Stat. ch. §37.627.669* Effective 1993	Group insurers, HMOs, and nonprofit health care service plans.	*"Substance abuse impaired"* means a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.	**Substance abuse mandated offer requirements:** Requires affected entities to offer coverage for the necessary care and treatment of substance abuse impaired persons. **Scope of coverage:** Requires inpatient or outpatient benefits to consist of intensive treatment programs for the treatment of substance abuse impaired persons. • Requires: ▪ benefits to be available to covered individuals only; ▪ a minimum lifetime benefit of $2,000; ▪ a maximum of 44 outpatient visits (does not include detoxification); and ▪ a maximum benefit payable for an outpatient visit of $35. **Benefit management:** Requires benefits to be payable only if prescribed by a licensed physician or psychologist and if services are provided in a program accredited by the Joint Commission on Accreditation of Healthcare Organizations.

State law	Applicability	Definitions	Major provisions
Georgia *Ga. Code Ann. §33-24-28.3* Effective 1998	Insurers, nonprofit medical and hospital service plans, health care plans, fraternal benefit societies, and HMOs.	No definitions.	**Substance abuse coverage requirements:** Does not mandate coverage for substance abuse. **Scope of coverage:** Prohibits affected entities that provide benefits for the treatment of alcoholism or drug addiction, from denying payment solely because a hospital specializes in the treatment of alcoholics or drug addicts and is operated primarily for the treatment of such persons.
Georgia *Ga. Code Ann. §33-24-28.1* Effective 1981 Amended 1998	Individual accident and sickness insurance benefit plan, policy, or contract.	*"Mental disorder"* means all disorders in the DSM or ICD classification.	**Mental health mandated offer requirements:** Requires affected entities to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage, coverage for the treatment of mental disorders. **Scope of coverage:** Requires such optional overage to be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. • Requires such optional coverage to cover at least 30 inpatient treatment days and 48 outpatient visits annually. • Prohibits the optional endorsement from containing any exclusions, reductions, or other limitations as to coverage, deductibles, or coinsurance provisions which apply to the treatment of mental disorders unless such provisions apply generally to other similar benefits provided or paid for under the benefit plan, policy, or contract.
Georgia *Ga. Code Ann. §33-24-29* Effective 1998	Group or blanket accident and sickness insurance plans or contracts providing major medical benefits. Does not apply to policies issued to an employer in another state which provide coverage for employees in another state who are em-	*"Mental disorder"* means the same as defined in the DSM or ICD.	**Mental health mandated offer requirements:** Requires affected entities to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage, coverage for the treatment of mental disorders. **Mental health coverage requirements:** Prohibits affected entities from offering coverage for the treatment of mental disorders with annual and lifetime dollar limits that are more extensive than those for physical illnesses. **Scope of coverage:** Prohibits affected entities from including different exclusions, reductions, or other limitations than physical illnesses, except with respect to limits on inpatient treatment days and outpatient treatment visits.

State law	Applicability	Definitions	Major provisions
	ployed by such employer, providing major medical benefits covering small groups.		• Permits differences in deductibles or coinsurance to the extent that they do not exceed the deductible for physical illnesses. • Limits out-of-pocket costs for individuals to $2,000 as of 1998 with annual adjustments thereafter according to the CPI for health care.
Hawaii *Haw. Rev. Stat. §431M, et. seq.* Effective 1988 Amended 2007	All individual and group accident and health or sickness insurance policies, individual or group hospital or medical service plan contracts, nonprofit mutual benefit societies, and HMO contracts. Does not apply to specified disease policies or other specialized coverage.	*"Alcohol dependence"* means any use of alcohol which produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal. *"Drug dependence"* means any pattern of pathological use of drugs causing impairment in social or occupational functioning and producing psychological or physiological dependency or both, evidenced by physical tolerance or withdrawal. *"Mental illness"* means a syndrome of clinically significant psychological, biological, or behavioral abnormalities those results in personal distress or suffering, impairment of capacity for functioning, or both as defined in the DSM or ICD. • Provides that epilepsy, senility, mental retardation, or other developmental disabilities and addiction to or abuse of intoxicating substances do not in and of themselves constitute a mental disorder.	**Mental health and substance abuse coverage requirements:** Requires affected entities to cover services for the treatment of mental illness and alcohol and drug dependency. **Scope of mental health and substance abuse coverage:** Prohibits inpatient hospital services from being less than 30 days per year. • Prohibits visits to physicians, psychologists, licensed clinical social workers, marriage and family therapists, or advanced practice RNs with a psychiatric or mental health specialty or subspecialty of less than 30 visits per year in a hospital, non-hospital facility, or to a mental health outpatient facility. • Permits a 2:1 day exchange ratio of non-hospital residential services, partial hospitalization, or day treatment services with in-hospital services. • Prohibits the total covered benefit for outpatient services of less than 24 visits per year (two of the 24 visits shall apply only to mental health). • Limits covered benefits for alcohol and mental illness treatment to services provided by a physician, psychologist, licensed clinical social worker, marriage and family therapist, or advanced practice RN as medically or psychologically necessary at the least restrictive appropriate level of care. • Requires covered benefits for mental illnesses to be subject to review procedures (including prior, concurrent, and retrospective review) as a condition of payment or reimbursement. • Requires services to be provided as part of an individualized treatment plan that is reasonably expected to improve the patient's condition. **Scope of substance abuse coverage:** Requires detoxification services to be provided in a hospital or in a non-hospital facility which has a written affiliation agreement with a hospital for emergency, medical, and mental health support services. • Requires coverage of: ▪ room and board; ▪ diagnostic x-rays; ▪ laboratory testing and drugs; ▪ equipment use;

State law	Applicability	Definitions	Major provisions
		"Serious mental illness" means schizophrenia, schizo-affective disorder, and bipolar disorder as defined in the most recent version of the DSM, which is of sufficient severity to result in substantial interference with the activities of daily living.	▪ special therapies; and ▪ supplies. • Requires alcohol or drug dependence treatment coverage through in-hospital, non-hospital residential, or day treatment substance abuse services to be provided in a hospital or non-hospital facility to the extent a physician, psychologist, licensed clinical social worker, marriage and family therapist, or advanced practice RN determines that the person suffers from alcohol or drug dependence, or both. ▪ Excludes judicially referred detoxification services and educational programs. ▪ Requires at least 2 treatment episodes per lifetime. • Requires detoxification services to be part of the covered in-hospital services, but not in the treatment episode limitation of the mental health coverage requirements.
Idaho *Idaho Code §67-5761A* Effective 2006	State employees group health coverage.	*"Serious mental illness"* means any of the following psychiatric illnesses as defined by the American psychiatric association in the(DSM-IV): • schizophrenia; • paranoia and other psychotic disorders; • bipolar disorders (mixed, manic, and depressive); • major depressive disorders (single episode or recurrent); • schizoaffective disorders (bipolar or depressive); • panic disorders; and • obsessive-compulsive disorders. *"Serious emotional disturbance"* means an emotional or behavioral disorder, or a neuropsychiatric condition, which: results in a serious disability; requires sustained	**Mental health coverage requirements:** To be considered nondiscriminatory and equitable, requires state employees group health care service coverage to provide benefits and cover services that are essential to the effective treatment of serious mental illnesses and serious emotional disturbances in a manner that: • is not more restrictive or more generous than benefits and coverages provided for other major illnesses; • provides clinical care, but does not require partial care, of serious mental illness or serious emotional disturbance; and • is consistent with effective and common methods of controlling health care costs for other major illnesses. **Cost report:** Requires the Department of Administration to submit a report to the Legislature and to the Legislative Health Care Task Force by 01/31/10, indicating any additional costs incurred in providing the required coverage for the first three-year period.

State law	Applicability	Definitions	Major provisions
		treatment interventions; and causes the child's functioning to be impaired in thought, perception, affect, or behavior. • A disorder is considered to "result in a serious disability" if it causes substantial impairment of functioning in family, school, or community. While a substance abuse disorder may coexist with a serious emotional disturbance, it does not, by itself, constitute a serious emotional disturbance.	
Illinois *215 Ill. Comp. Stat. 5/370c* Effective 1991 Amended 2008	Mental health coverage offering requirements apply to every insurer delivering, issuing for delivery, or renewing or modifying group accident and health policies providing coverage for hospital or medical treatment or services for illnesses on an expense-incurred basis. Mental health coverage requirements apply to insurers amending, delivering, issuing, or renewing group accident and health policies providing for hospital or medical expenses.	*"Serious mental illness"* means the following disorders as defined in the most current edition of the DSM: • schizophrenia; • paranoid and other psychotic disorders; • bipolar disorders (hypomanic, manic, depressive, and mixed); • major depressive disorders (single episode or recurrent); • schizoaffective disorders (bipolar or depressive); • pervasive developmental disorders; • obsessive-compulsive disorders: • depression in childhood and adolescence; • panic disorders; • post-traumatic stress disord-	**Mental health coverage requirements:** Requires affected entities to provide coverage for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. • Requires coverage for serious mental illnesses to be provided for the same durational and amount limits, deductibles, and co-insurance requirements as are provided for other covered illnesses and diseases. • Requires affected entities to *offer* to the applicant or group policyholder coverage for reasonable and necessary treatment and services for mental, emotional, or nervous disorder or conditions, other than serious mental illnesses, up to the limits provided in the policy for other disorders or conditions. ▪ Permits a requirement for the insured to pay up to 50% of expenses incurred as a result of treatment or services, and an annual benefit limit of the lesser of $10,000 or 25% of the lifetime policy limit. ▪ Permits insureds to select a physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor of their choice to treat covered mental, emotional, or nervous disorders or conditions. **Scope of coverage:** For medically necessary treatment on an annual basis, requires coverage of 45 days of inpatient and 60 outpatient visits (including group and individual outpatient visits). • Prohibits the imposition of a lifetime limit on the number of days of inpatient

State law	Applicability	Definitions	Major provisions
	Mental health coverage requirements do not apply to coverage provided by employers who have 50 or fewer employees.	ers (acute, chronic, or with delayed onset); and • anorexia nervosa and bulimia nervosa. Does not require coverage for treatment of an addiction to or a mental illness resulting from an illegal use of a controlled substance or cannabis.	treatment or the number of outpatient visits. • Requires the same amount limits, deductibles, co-pays, and coinsurance factors for serious mental illness as are imposed for physical illnesses. • Requires outpatient visits to be covered under the same terms and conditions applicable for outpatient visits for the treatment of physical illnesses. **Benefit management:** Permits coverage to be provided through a managed care plan. • Permits the reimbursing insurer to request, and requires a provider of treatment of serious mental illness to furnish, medical records or other necessary data to substantiate that initial or continued treatment is at all times medically necessary. • Requires a review process for medical necessity disputes arising between the insurer the patient's provider. Upon determination that a treatment is medically necessary, requires the insurer to provide reimbursement for such treatment. • Requires insurers to make medical necessity determinations for the treatment of serious mental illness in a manner consistent with that used for other covered diseases or illnesses.
Illinois *215 Ill. Comp. Stat. 5/367* Effective 1995	Group accident and health insurance policies.	No definitions.	**Substance abuse coverage requirements:** Requires affected entities providing inpatient hospital coverage for sickness to include coverage for the treatment of alcoholism.
Indiana *Ind. Code §§27-8-5-15.5 and 27-13-7-14.8* Effective 1992 Amended 1993	Group and individual policies offered by accident and sickness insurers.	*"Alcohol abuse"* means repeated episodes of intoxication or drinking which impair health or interfere with an individual's effectiveness on the job, at home, in the community, or operating a motor vehicle. *"Drug abuse"* means the following if harmful to the individual or society: 1. psychological or physical de-	**Mental health and substance abuse coverage requirements:** Prohibits affected entities providing coverage for inpatient services for the treatment of mental illness, substance abuse, or both from excluding coverage for inpatient services for the treatment of mental illness or substance abuse that are provided by a community mental health center or by any psychiatric hospital licensed by the state department of health or the division of mental health and addiction to offer those services.

State law	Applicability	Definitions	Major provisions
		pendence on the effect of drugs or harmful substances; or 2. abuse of the use of drugs or harmful substances. *"Mental illness"* means a psychiatric disorder that: • substantially disturbs an individual's thinking, feeling, or behavior; and • impairs the individual's ability to function. The term includes mental retardation, alcoholism, and addiction to narcotics or dangerous drugs. *"Substance abuse"* means drug or alcohol abuse.	
Indiana *Ind. Code §§27-8-5-15.6 and 27-13-7-14.8* Effective 1992 Amended 1995	Group and individual policies offered by accident and sickness insurers, HMOs, and state employee health benefit plans. Does not apply to accident-only, credit, dental, vision, Med Supp, long-term care, disability income, workers comp, supplemental liability, auto medical, specified disease, short-term insurance, limited benefit plans issued as individual policies, and	*"Coverage of services for a mental illness"* means those services defined under the policy. • The term does not include services for the treatment of substance abuse or chemical dependency.	**Mental health and substance abuse parity requirements:** Does not require the affected entities to offer mental health benefits. • For individual policies and group policies issued to employers with more than 50 employees that provide coverage for mental illness, prohibits the imposition of treatment limits or financial requirements for services for mental illness unless such limits or requirements are also imposed on coverage for medical or surgical conditions. • For individual and group policies issued to employers with more than 50 employees that provide coverage for treatment of substance abuse and chemical dependency, prohibits the imposition of treatment limits or financial requirements for those services unless such limits and requirements are imposed on coverage for medical or surgical conditions. **Benefit management:** Permits benefits to be delivered under a managed care system. **Exemption for cost increases:** Permits a policy to not comply with the above parity requirements if the coverage causes a premium increase of more than 4%.

State law	Applicability	Definitions	Major provisions
	policies stipulating daily, weekly, or monthly payments to an insured during hospital confinement.		
Iowa *Iowa Code §514C.22* Effective 2005 *Iowa Administrative Code §191 - 35.3(509)(3)* Effective 2006	Public employee programs and carriers issuing group policies, contracts, or plans providing for third-party payment or prepayment of health, medical, and surgical coverage benefits, or an organized delivery system. Applies to such policies, contracts, or plans issued to employers with 50 or more full-time employees providing coverage for the treatment of mental illness. Does not apply to: accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner; dis-	*"Biologically based mental illness"* means the following psychiatric illnesses as defined under the most current edition of the DSM: • schizophrenia, including all specific subtypes of schizophrenia; • bipolar disorders, including all specific types of bipolar disorders; • major depressive disorders, including all specific subtypes of major depressive disorders; • schizo-affective disorders; • obsessive-compulsive disorders; • pervasive developmental disorders; and • autistic disorders.	**Mental health coverage requirements:** Requires affected entities to provide coverage for biologically based mental illnesses. **Scope of coverage:** Prohibits affected entities from imposing an aggregate annual or lifetime limit on biologically based mental illness coverage benefits unless the policy, contract, or plan imposes such limits on substantially all health, medical, and surgical coverage benefits. • Requires affected entities to impose the same deductibles, coinsurance, or copayments for health, medical, surgical, and mental health services. • Requires affected entities to, at a minimum, allow for 30 inpatient days and 52 outpatient visits annually. • Permits affected entities to exclude from coverage benefits for the cost of providing: ▪ marital, family, educational, developmental, or training services; ▪ custodial care; ▪ services and supplies that are not medically necessary or clinically appropriate; and ▪ experimental treatments. **Benefit management:** Permits affected entities to manage mental health benefits through "common methods" including, but not limited to: • capitated payment systems; • prospective reimbursement rate systems; • utilization control systems; • incentive systems for the use of least restrictive and least costly levels of care; • PPOs; or • any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

State law	Applicability	Definitions	Major provisions
	ability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance; or individual accident and sickness policies issued to individuals or to individual members of a member association.		
Kansas *Kan. Stat. Ann. §40-2,105 [as amended by H.B. 2214 (2009)]* Effective 1998 Amended 2009	Insurers or HMOs offering individual or small employer (defined as 2-50 employees) accident and sickness policies. Does not apply to Medicare supplement policies.	*"Mental illness, alcoholism, drug abuse or substance use" means* disorders specified in the DSM-IV. *"Treatment limitations"* includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.	**Mental health coverage requirements:** Requires affected entities to provide for reimbursement for alcoholism, drug abuse, or other substance abuse disorders as specified below. **Scope of coverage:** Requires affected entities to provide: • not less than 45 inpatient days annually for in-patient treatment of mental illness in a licensed facility;, • not less than 30 days annually when a person is confined for the treatment of alcoholism, drug abuse or substance abuse disorders in a licensed medical care facility, a treatment facility for alcoholics or drug abusers, community mental health centers or clinics, or a psychiatric hospital; and • the same deductibles, co-pays, coinsurance, out-of-pocket expenses and treatment limitations as apply to other covered services, limited to not less than a $15,000 lifetime limit, with no annual limits when in-patient treatment is not necessary for the treatment or by a licensed Kansas physician or psychologist. **Benefit Management:** Allows affected entities to perform utilization review for mental illness, so long as it is conducted in accordance with Kansas' utilization review laws.
Kansas *Kan. Stat. Ann.*	Any group health insurance policy, medical or	*"Mental illness, alcoholism, drug abuse or substance use"* means	**Mental health and substance abuse coverage requirements:** Requires affected entities to include coverage for the diagnosis and treatment of mental illnesses and

State law	Applicability	Definitions	Major provisions
§40-2, 105a [as amended by H.B. 2214 (2009)] Effective 1998 Amended 2009	hospital service plan contract, fraternal benefit society or HMO providing medical, surgical or hospital expense coverage. • Also applies to the state employee health care benefits program and municipal funded pools. Does not apply to small employers (defined as 2-50 employees). • Also does not apply to specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, Medicare supplement, or any other limited supplemental benefit policy.	any disorder as such terms are defined in the DSM-IV. *"Treatment limitations"* includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.	alcoholism, drug abuse, or other substance use disorders. • Requires coverage to be subject to the same deductibles, co-pays, coinsurance, out-of-pocket expenses, treatment limitations, and other limits applied to other covered services. **Scope of coverage**: Requires reimbursement to be provided for treatment in a licensed adult care home, drug abuse treatment facilities, community mental health centers or clinics, psychiatric hospitals, or by a licensed physician or psychologist. • Requires coverage to include treatment for inpatient and outpatient care for mental illness, alcoholism, and drug abuse or substance use disorders. **Benefit Management:** Allows affected entities to perform utilization review for mental illness, so long as it is conducted in accordance with Kansas' utilization review laws.
Kansas *Kan. Stat. Ann. §40-2258 [as amended by H.B. 2214 (2009)]*	Insurers offering coverage through a group policy or certificate providing hospital, medical or surgical expense benefits.	*"Mental illness benefits"* means benefits with respect to mental health services, as defined under the terms of the policy. *"Alcoholism, drug abuse or sub-*	**Mental health and substance abuse parity requirements:** Does not require the affected entities to offer mental illness or alcoholism, drug abuse or other substance use disorders benefits. **Scope of coverage:** Prohibits affected entities that do not include an aggregate lifetime or annual limit on substantially all hospital, medical, and surgical expense

State law	Applicability	Definitions	Major provisions
Effective 2009	Does not apply to group accident and health insurance policies sold to a small employer (defined as 2 – 50 employees).	*stance use disorder benefits"* means benefits with respect to services for the treatment of alcoholism, drug abuse or other substance use disorders, as defined under the terms of the policy. *"Mental illness, alcoholism, drug abuse or substance use"* means disorders as specified in the DSM-IV.	benefits from imposing an aggregate lifetime or annual limit on mental illness or alcoholism, drug abuse or other substance use disorders benefits. • Requires affected entities that include an aggregate lifetime or annual limit on substantially all hospital, medical and surgical expense benefits, requires the plan to either: ▪ apply the applicable limit both to the hospital, medical, and surgical expense benefits and the mental illness, alcoholism, drug abuse, or other substance use disorder benefits and not distinguished in the application of such limit between the types of benefits; or ▪ not include any limit on mental illness, alcoholism, drug abuse, or other substance use disorder benefits that is less than the applicable limit on hospital, medical, and surgical expense benefits. ▪ Allows the Commissioner to adopt rules to address situations where the group policy does not apply a lifetime or annual benefit or applies different lifetime or annual benefits to different categories of hospital, medical, and surgical expense benefits that substitutes an average limit for the applicable lifetime or annual limits that takes in to account the weighted average of the lifetime or annual limits applicable to such categories. **Benefit management:** Provides that the law is not to be construed as affecting any terms and conditions of a policy which does include mental illness or alcoholism, drug abuse or other substance use disorders benefits, including provisions regarding: cost sharing; limits on the number of visits or days of coverage; requirements relating to medical necessity; and requirements relating to the amount, duration, or scope of mental illness or alcoholism, drug abuse or other substance use disorders benefits. **Exemption for cost increases:** Provides that the requirements do not apply if the coverage mandate will result in an increase in the cost under the plan of at least 2 percent in the first plan year and 1 percent in each subsequent plan years. • Requires determinations as to increases in actual costs under a plan to be made in writing and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.
Kentucky *Ky. Rev. Stat. Ann. §§304.18-130, 304.18-140,*	Insurers providing major medical or outpatient care benefits contracts.	*"Alcohol and other drug abuse"* means a dysfunctional use of alcohol or other drugs or both, characterized by one or more of the	**Substance abuse mandated offer requirements:** Requires affected entities to offer the master policyholder the option to purchase in new contracts the minimum benefits for treatment of alcoholism.

State law	Applicability	Definitions	Major provisions
304.18-160; and 222.005 Effective 1980	Does not apply to disability and accident income benefits and basic health care contracts that do not provide major medical or outpatient care.	following patterns of use: • the continued use despite knowledge of having a persistent or recurrent social, legal, occupational, psychological, or physical problem that is caused or exacerbated by use of alcohol or other drugs or both; • use in situations which are potentially physically hazardous; • loss of control over the use of alcohol or other drugs or both; and • use of alcohol or other drugs or both is accompanied by symptoms of physiological dependence, including pronounced withdrawal syndrome and tolerance of body tissues to alcohol or other drugs or both. *"Treatment for alcoholism"* means services and programs for the care and rehabilitation of intoxicated persons and persons suffering from alcohol and other drug abuse, including: • detoxification services on a twenty-four (24) hour basis in or near population centers which meet the immediate medical and physical needs of persons intoxicated from the use of alcohol or drugs, or both, including necessary diagnostic and referral services.	**Scope of coverage:** Requires coverage for treatment to be divided into: ▪ emergency detoxification treatment (three days, $40 a day); ▪ residential treatment (10 days, $50 a day); and ▪ outpatient treatment (10 visits, $10 a visit). • Conditions coverage on completion of a program of treatment under the guidance of a Kentucky physician or a professional designated by such physician who is a staff member of a treatment facility accredited by the Joint Commission on Accreditation of Hospitals.

State law	Applicability	Definitions	Major provisions
		The services shall be provided in either a hospital or a licensed alcohol and other drug abuse program; • rehabilitation services offered on an inpatient or outpatient basis for the purposes of treating an individual's alcohol and other drug abuse problem in a licensed alcohol and other drug abuse program; and • involuntary treatment ordered for a person suffering from alcohol and other drug abuse.	
Kentucky *Ky. Rev. Stat. Ann. §304.18-036* Effective 1987	Group policies or contracts of general health insurance.	*"Mental illness"* means psychosis, neurosis or an emotional disorder.	**Mental health mandated offer requirements:** Requires affected entities to include an offer of coverage for the inpatient and outpatient treatment of mental illness, at least to the same extent and degree as coverage provided for the treatment of physical illness.
Kentucky *Ky. Rev. Stat. Ann. §§304.17A-660, 304.17A- 661, and 304.17A-665* Effective 2000 Amended 2002	Health benefit plans which includes any: hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a MEWA, to the extent permitted by ERISA;	*"Mental health condition"* means any condition or disorder that involves mental illness or alcohol and other drug abuse as defined in statute and that falls under any of the diagnostic categories listed in the DSM-IV or ICD.	**Mental health parity requirements:** Requires health benefit plans providing coverage for treatment of mental health conditions to provide coverage of any treatment for a mental health condition under the same terms and conditions as provided for treatment of a physical health condition. **Scope of coverage:** Requires treatment of a mental health condition including, but not limited to: outpatient, inpatient, residential, partial hospitalization, day treatment, emergency detoxification, or crisis stabilization services. • Requires expenses for mental health and physical conditions to be combined for purposes of meeting deductible and out-of-pocket limits required under the health benefit plan. • Permits a health benefit plan that does not otherwise provide for management of care under the plan or does not provide for the same degree of management of care for all health or mental conditions to provide coverage for treatment of mental health conditions through a managed care organization.

State law	Applicability	Definitions	Major provisions
	and HMO contract. Does not apply to group health benefit plans covering fewer than 51 employees, or to individual health benefit plans. Does not apply to standard health benefit plans excluding coverage for mental health conditions that had excluded such conditions on January 1, 2000. Does not apply to: policies covering only accident, credit, dental, or disability income; fixed indemnity medical expense reimbursement policies; long-term care, Medicare supplement, specified disease, or vision care policies; short-term coverage; student insurance; medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract; or limited health service benefit plans.		**Cost report:** Requires the Commissioner, 60 days prior to even-numbered-year regular sessions of the Generally Assembly, to submit a report to the Legislative Research Commission on the cost impact of the mental health coverage requirements.

State law	Applicability	Definitions	Major provisions
Louisiana *La. Rev. Stat. Ann. §22:669* Effective 2000	Hospital, health, or medical expense insurance policies, hospital or medical service contracts, employee welfare benefit plans, contracts or other agreements with a HMO or PPO, health and accident insurance policy, or other insurance contract of this type, including group insurance plans, self-insurance plans, and the state employee's group benefits program. Does not apply to individually underwritten health insurance plans, short term limited duration health insurance policies, and individually underwritten limited benefit and supplemental health insurance policies.	*"Severe mental illness"* means: • schizophrenia or schizoaffective disorder; • bipolar disorder; • pervasive developmental disorder or autism; • panic disorder; • obsessive-compulsive disorder; • major depressive disorder; • anorexia/bulimia; • Asperger's disorder; • intermittent explosive disorder; • posttraumatic stress disorder; • psychosis not otherwise specified (NOS) when diagnosed in a child under 17; • Rett's disorder; and • Tourette's disorder.	**Mental health coverage requirements:** Requires affected entities to provide benefits payable for the treatment of severe mental illness under the same circumstances and conditions as benefits are paid under policies for all other diagnosis, illnesses, or accidents. • Requires affected entities to also offer an optional provision to cover treatment of mental disorders other than severe mental illness under the same circumstances and conditions as benefits paid for all other diagnoses, illnesses, or accidents. **Scope of coverage:** Requires a minimum of 45 inpatient days per covered individual, per calendar year. ▪ Allows the exchange of two days of partial hospitalization or residential treatment for each day of inpatient treatment. • Requires 52 outpatient visits per covered individual per calendar year, including an intensive outpatient program. • Allows the exchange of 1 inpatient day of treatment for 4 outpatient visits. • Requires benefits to be payable when the treatment or services are rendered a Louisiana licensed physician or psychologist, or when the treatment or services in connection with diagnostic consultation provided by a physician are rendered by a licensed clinical social worker who is a member of a national clinical social work registry. • Prohibits provisions for a waiting period in excess of 60 days from the policy's effective date before benefits are payable for the treatment of severe mental illness or other mental disorders. **Benefit management:** Allows the management of mental health benefits through such methods as pre-admission screening prior to authorization of services or any other mechanism designed to limit coverage for services for mental disorders only to those deemed medically necessary by a licensed mental health professional.
Louisiana *La. Rev. Stat. Ann. §22:215.5* Effective 1982	Group, blanket, and franchise health insurance.	No definitions.	**Substance abuse mandated offer requirements:** Requires affected entities to include an option for benefits for the treatment of alcoholism and drug abuse rendered or prescribed. **Scope of coverage:** If coverage is provided, requires covered services to be prescribed by a Louisiana licensed physician and received in a hospital or other public

State law	Applicability	Definitions	Major provisions
			or private facility, or portion thereof, licensed and authorized by the appropriate state authority to provide such treatment.
Maine *Me. Rev. Stat. Ann. Tit. 24A, §2842* Effective 1984	Insurers issuing group health care contracts providing hospital care. Does not apply to employee group insurance policies with 20 or fewer employees.	No definitions.	**Substance abuse coverage requirements:** Requires affected entities to provide benefits as required to any subscriber or other person covered under those contracts for the treatment of alcoholism and other drug dependency pursuant to a treatment plan. • Requires affected entities to provide written notification to all eligible individuals of these alcoholism and drug dependency benefits. **Scope of coverage:** Requires minimum benefits to include (pursuant to a treatment plan) state licensed residential treatment at a hospital or free-standing residential treatment center and outpatient care provided by state licensed providers. • Permits policies to contain provisions for maximum benefits and coinsurance, and reasonable limits, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements. **Reports to Superintendent:** Requires affected entities to annually report to the Superintendent of Insurance their experience with providing these benefits, including claims information.
Maine *Me. Rev. Stat. Ann. Tit. 24A, §2843* Effective 1996	Insurers issuing group health care contracts. Does not apply to employee group insurance policies with 20 or fewer employees. Does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care, or other limited benefit health insurance policies.	*"Person suffering from mental illness"* means a person whose psychobiological process are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Also requires such person to: • have a disorder of thought, mood, perception, orientation or memory which impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life; and • manifest an impaired capaci-	**Mental health coverage requirements:** Requires affected entities to provide benefits for treatment for mental illness. • Requires contracts to provide for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than benefits provided for treatment for physical illnesses. **Scope of coverage:** Requires affected entities to provide medically necessary health care to a person suffering from mental illness, including, but not limited to: inpatient care, outpatient care, day treatment services, and home health care services. • Requires mental illness to be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. • Prohibits separate maximums, deductibles, coinsurance amounts, office visit limits for physical and mental illness, and separate out-of-pocket limits in a benefit period of not more than 12 months for physical and mental illness.

State law	Applicability	Definitions	Major provisions
		ty to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being. *"Mental illness"* means any of the following categories of mental illness as defined in the DSM, except for those that are designated "V" codes: • psychotic disorders, including schizophrenia; • dissociative disorders; • mood disorders; • anxiety disorders; • personality disorders; • paraphilias; • attention deficit and disruptive behavior disorders; • pervasive developmental disorders; • tic disorders; • eating disorders, including bulimia and anorexia; and • substance abuse-related disorders.	• Prohibits limitations on coverage or benefits for mental illness unless the same limitation is also imposed for physical illness. • Requires co-pays for mental illness to be actuarially equivalent to any physical illness coinsurance requirements or, if there are no coinsurance requirements, prohibits co-pays from exceeding co-pays or coinsurance for a physical illness. • Requires medication management visits associated with a mental illness to be covered in the same manner as such visit for the treatment of a physical illness and prohibits such visits from being calculated in any maximum outpatient visit limit. • Permits policies to contain provisions for maximum benefits and coinsurance, and reasonable limits, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements. **Benefit management:** Requires a provider, when making medically necessity determinations, to use the same criteria for treatment for mental illness as for treatment for physical illness under the group contract. • Permits mental health benefits and coverage to be provided on a separate managed care system if benefits and coverage provided for treatment of physical illness are provided on an expense-incurred basis. **Reports to Superintendent:** Requires affected entities to annually report to the Superintendent of Insurance their experience with providing these benefits, including claims information.

State law	Applicability	Definitions	Major provisions
Maine *Me. Rev. Stat. Ann. Tit. 24A, §§2835 and 2744* Effective 2004 Amended 2006	Insurers offering group and individual health policies.	*"Professionals"* means: • psychologists licensed to practice in ME; • certified social workers licensed for the independent practice of social work in ME; • licensed clinical professional counselors licensed for the independent practice of counseling in ME; • licensed nurses certified by the American Nurses' Association as clinical specialists in adult psychiatric and mental health nursing or as a clinical specialists in child and adolescent psychiatric and mental health nursing; • marriage and family therapists licensed as a marriage and family therapists in ME; and • licensed pastoral counselors licensed as pastoral counselors in ME.	**Mental health coverage requirements:** Requires a policy that pays or reimburses for services within the lawful scope of practice of a health professional to provide reimbursement for these services if the services are performed by a physician or a professional. • Requires affected entities providing coverage for mental health services to offer coverage for those services when performed by a counseling professional licensed in ME.
Maryland *Md. Code Ann. Ins. §15-802* Effective 1994 Amended 2005	Individual and group health insurance policies.	No definitions.	**Mental health parity requirements:** Requires affected entities to provide benefits for the diagnosis and treatment of mental illness, emotional disorder, drug abuse disorder, and alcohol abuse disorder under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illnesses. **Scope of coverage:** Requires the following minimum benefits: ▪ a number of days for inpatient benefits at a licensed facility, including hospital inpatient benefits, and terms and conditions that apply to those benefits at least equal to those that apply to the benefits available under

State law	Applicability	Definitions	Major provisions
			the policy or contract for physical illnesses; ▪ 60 days of partial hospitalization under the same terms and conditions that apply for physical illnesses; and ▪ outpatient coverage, including psychological and neuropsychological testing for diagnostic purposes, at a rate, after the deductible, that is not less than: 80% for the first five visits annually; 65% for visits 6-30 annually; 50% for the 31st and any subsequent visit annually. • Prohibits separate lifetime limits, deductibles, coinsurance, and out-of-pocket limits for physical and mental illnesses. • Requires co-pays to be actuarially equivalent to any other coinsurance requirements or if there are no coinsurance requirements, prohibits co-pays for mental illness, emotional disorders, or drug and alcohol disorders that are greater than those required for physical illness. **Benefit management:** Limits benefits to medically necessary services for treatable conditions • Permits benefits to be delivered under a managed care system.
Maryland *Md. Code Ann. Ins.§19-703.1* Effective 2005	HMOs	No definitions.	**Mental health parity requirements:** Requires affected entities to provide benefits for the diagnosis and treatment of mental illnesses, emotional disorders, drug abuse disorders, and alcohol abuse disorders under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illnesses. **Scope of coverage:** Requires the following minimum benefits to be provided: • inpatient benefits in a licensed or certified facility (including hospital inpatient benefits); • 60 days of partial hospitalization; and • outpatient coverage, including psychological and neuropsychological testing for diagnostic purposes, at a rate, after the applicable deductible, of not less than 80% for the first 5 visits annually, 65% for visits 6-30 annually, and 50% for the 31st and any subsequent visit annually.
Massachusetts *Mass. Gen. Laws Ch. §§175.47B, 176G.4M, and*	Insurers offering group blanket or general accident and sickness insurance policies, HMOs,	*"Biologically based mental disorders"* means the following disorders as defined in the DSM: • schizophrenia;	**Mental health coverage requirements:** Requires affected entities to provide mental health benefits on a non-discriminatory basis for the diagnosis and treatment of biologically based mental disorders. • Also applies to rape-related disorders and to children and adolescents under the

State law	Applicability	Definitions	Major provisions
32A.22 Effective 1996 (for state employee plans) and 2001 (for other entities) Amended 2008	and individual accident and sickness policies. Also applies to group insurance commission coverage (the state employee plan).	• schizo-affective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders; • obsessive-compulsive disorder; • panic disorder; • delirium and dementia; • affective disorders; • affective disorders; • eating disorders; • post traumatic stress disorder; • substance abuse disorders; and • autism.	age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral, or emotional disorders as described in the DSM which substantially interfere with or limit the functioning and social interactions of such a child or adolescent. **Scope of coverage:** Prohibits differences in annual and lifetime dollar limits between physical and outlined mental disorders. • Requires coverage of medically necessary care for 60 days of inpatient treatment and a minimum of 24 outpatient visits annually. • Requires benefits to consist of a range of inpatient, intermediate and outpatient services that permit medically necessary and active and non-custodial treatment for outlined mental disorders to take place in the least restrictive clinically appropriate setting. • Permits services to be obtained from a general hospital licensed to provide mental health services, private mental hospital, substance abuse facility, community based detoxification center, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health.
Massachusetts *Mass. Gen. Laws Ch. §175.110(H)* Effective 1991	Any blanket or general policy of insurance.	No definitions.	**Substance abuse coverage requirements:** Requires affected entities to provide benefits for expenses arising from treatment of alcoholism. **Scope of coverage:** Requires the following minimum coverage: • 30 days annually for inpatient care with an accredited organization, including detoxification or rehabilitation services; and • $500 dollars annually for outpatient care at an accredited or licensed hospital or public/private facility with rehabilitation services.
Michigan *Mich. Comp. Laws §500.3425* Effective 1982	Group and individual insurers offering health insurance.	*"Substance abuse"* means the taking of alcohol or other drugs: • at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard; or • to the extent that an individual loses the power of self-	**Substance abuse parity requirements:** Requires affected entities to provide coverage for intermediate and outpatient care for substance abuse. • Prohibits charges, terms, and conditions for required coverage from being less favorable than the maximum prescribed for any other comparable service. **Scope of coverage:** Imposes minimum coverage of $1,500 for intermediate and outpatient care for substance abuse annually. • Clarifies that provisions do not prohibit deductibles and co-pays for coverage for intermediate and outpatient care for substance abuse.

State law	Applicability	Definitions	Major provisions
		control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.	**Exemption for cost increases:** In the case of group insurance policies, allows the policyholder to decline coverage if the premium for the group would be increased by 3% percent or more because of the required coverage. • In the case of individual policies, allows the named insured to decline coverage if the premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the required coverage.
Michigan *Mich. Comp. Laws §500.3501* Effective 2001	HMOs.	No definitions.	**Mental health and substance abuse parity requirements:** Prohibits charges, terms, and conditions for the services required from being less favorable than the maximum prescribed for any other comparable service. **Scope of coverage:** Requires coverage to include 20 outpatient visits per year for mental health and a minimum of $2,968 in services for intermediate and outpatient care for substance abuse each year. • Provides for the annual adjustment of the minimum amount by March 31st of each year in accordance with the annual average percentage increase or decrease in the CPI. **Exemption for cost increases:** Permits a group subscriber to decline the required services if fees for the group contract would increase by 3% or more because of the provision of such services.
Minnesota *Minn. Stat. §62A.149* Effective 1986	Insurers and non-profit health service plan corporations offering group accident and sickness policies contracts and policies of accident and individual policies.	No definitions.	**Substance abuse parity requirements:** Requires affected entities to provide benefits for the treatment of alcoholism, chemical dependency, or drug addiction on the same basis as for other benefits when treatment is rendered in a licensed hospital, a residential treatment program licensed in Minnesota pursuant to diagnosis or recommendation by a doctor of medicine, or a nonresidential treatment program approved or licensed in Minnesota. **Scope of coverage:** Requires coverage for hospital and residential treatment programs to be at least 20% of the total patient days allowed by the policy, and not less than 28 days annually. • Requires coverage in a nonresidential treatment program for at least 130 hours annually.

State law	Applicability	Definitions	Major provisions
Minnesota *Minn. Stat. §62Q.47* Effective 1995	Nonprofit health service plan corporations issuing group or individual policies of accident and health insurance. Does not apply to policies providing per diem, fixed indemnity, non-expense incurred, or accident-only coverage.	No definitions.	**Mental health and substance abuse parity requirements:** Requires all health plans that provide coverage for mental health or chemical dependency services to provide inpatient and outpatient services for such treatment that does not place a greater financial burden on the insured or enrollee, or that is more restrictive than those requirements and limitations for other inpatient and outpatient services. • Allows an individual under individual coverage to elect in writing to refuse benefits in exchange for an appropriate reduction in premiums.
Mississippi *Miss. Code Ann. §§83-9-27 and 83-9-31* Effective 1975	Any group coverage offered by accident or sickness insurers or nonprofit health plan corporations. Does not apply to individual policies.	*"Alcoholism"* is defined as the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.	**Substance abuse coverage requirements:** Requires affected entities to provide reimbursement for care and treatment of alcoholism in the same way as for loss resulting from sickness, or from bodily injury by accidental means. **Scope of coverage:** Prohibits coverage from exceeding $1,000 during any calendar year. • Extends benefits only to treatment and services rendered by a physician and hospitals licensed by the state where the service is rendered.
Mississippi *Miss. Code Ann. §83-9-39* Effective 2002	All alternative delivery systems and individual and group health insurance policies that do not offer mental health benefits. Does not apply to specified disease and other limited benefit health insurance policies.	No definitions.	**Mental health coverage requirements:** Requires affected entities with more than 100 eligible employees to provide covered benefits for the treatment of mental illness. • Requires affected entities of 100 or fewer eligible employees and to individuals to offer benefits for the treatment of mental illness, which the owner of the policy may reject in writing. **Scope of coverage:** Requires benefits to include inpatient and outpatient services certified as necessary by a provider. • Requires health service providers to certify that an individual is suffering from mental illness and refer such individual for the appropriate treatment before the individual may qualify to receive benefits. • Requires the exclusion for coverage of a pre-existing medical condition to be the same period of time as that for other medical illnesses covered under the same plan, program or contract.

State law	Applicability	Definitions	Major provisions
			Benefit management: Requires all mental illness treatment or services to be subject to professional utilization and peer-review procedures. **Exemption for cost increases:** Exempts coverage for treatment of mental illness if the application of these provisions results in an increase in the cost under the plan or coverage of 1%or more.
Missouri *Mo. Rev. Stat. §376.1550* Effective 2005	Health carriers offering or issuing health benefit plans, including those offered to state employees. Does not apply to individual coverage or supplemental insurance policies, including life, accident-only, specified disease, hospital policies providing a fixed daily benefit only, Medicare supplement, long-term care, hospitalization-surgical, or any other supplemental policy determined by the DOI.	*"Mental health condition"* means any condition or disorder defined by categories listed in the most recent edition of the DSM, except for chemical dependency.	**Mental health parity requirements:** Requires affected entities to provide coverage for a mental health condition and prohibits the establishment of any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. **Scope of coverage:** Requires any deductible or out-of-pocket limits to be comprehensive for coverage of all health conditions whether mental or physical. **Benefit management:** Permits mental health benefits to be offered through a managed care program. • Permits covered services to be delivered through a system of contractual arrangements with one or more providers, hospitals, residential or residential treatment programs. **Exemption for cost increases:** Permits coverage for treatment of mental health conditions to be waived if a policyholder can demonstrate by actual experience over any consecutive 24-month period that compliance increased the policyholder's premium by 2% or more.
Missouri *Mo. Rev. Stat. §§376.826, 376.827, 376.830, 376.833 and 376.836* Effective 2000 Amended 2004	Insurers providing group and individual health insurance policies. Does not apply to supplemental insurance policies, including life, accident-only, specified	*"Mental illness"* means the following disorders in the ICD-9: • schizophrenic disorders and paranoid states; • major depression; • bipolar disorder and other affective psychoses; • obsessive compulsive disorders;	**Mental health mandated offer requirements:** Requires affected entities to offer coverage for mental illnesses, including substance abuse, to the same extent as for other illnesses, with certain exceptions such as limits on the number of inpatient days for treatment of substance abuse or mental illness. • When read together with the requirements of §24.376.811 (see below), allows a policyholder who rejects the offer to opt for more limited coverage. • Requires a health insurance policy covering at least 1of the illnesses defined under mental illness, to cover all of the illnesses listed under mental illness. • Prohibits the establishment of any rate, term or condition that places a greater

State law	Applicability	Definitions	Major provisions
Sunset 01/01/11	disease, hospital policies providing a fixed daily benefit only, Medicare supplement, long-term care, hospitalization-surgical, or any other supplemental policy determined by the DOI.	• post-traumatic distress and other anxiety disorders; • early childhood psychoses and other disorders first diagnosed in childhood or adolescence; • alcohol and drugs abuse; • anorexia nervosa, bulimia and other severe eating disorders; and • senile organic psychotic conditions. The term does not include chemical dependency.	financial burden for treatment and evaluation of mental illnesses than would be placed on the enrollee for treatment and evaluation of a physical condition. **Scope of coverage:** Prohibits deductibles, co-pays, or coinsurance amounts for access to evaluation and treatment for mental illness from being "unreasonable" in relation to the cost of services provided. • Requires alcohol and other drug abuse services to have a minimum of 30 days inpatient treatment and 20 total outpatient visits for each year of coverage. • Permits a lifetime limit equal to four times such annual limits to be imposed for alcohol and drug abuse. • Permits the days for inpatient treatment for alcohol and drug abuse to be converted for use for outpatient treatment on a 2:1 basis. **Benefit management:** Permits coverage to be provided pursuant to a managed care program established by the affected entity. • Permits covered services to be delivered through a system of contractual arrangements with one or more licensed providers, community health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state.
Missouri *Mo. Rev. Stat. §§376.810 and.376.811* Effective 1997 Amended 2004	Chemical dependency provisions apply to every insurance company and health services corporation doing business in the state. Mental health provisions apply to every insurance company, health services corporation, and HMO doing business in the state. None of the provisions apply to supplemental insurance policies, in-	*"Recognized mental illness"* means those conditions classified as "mental disorders" in the DSM, but does not include mental retardation. *"Chemical dependency"* means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.	**Mental health mandated offer requirements:** Requires affected entities to offer coverage for recognized mental illness, excluding chemical dependency. • If the policyholder rejects the offer, provides that the coverage will be governed by §§24.376.825 to 24.376.835 (see above). **Scope of mental health coverage:** Requires minimum coverage offerings to include: ▪ outpatient treatment, including treatment through partial or full day program services for a recognized mental illness that are rendered by a licensed professional; ▪ residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness; and ▪ up to 90 days annually of inpatient hospital treatment for a recognized mental illness to the same extent as for other illnesses.

State law	Applicability	Definitions	Major provisions
	cluding life, accident-only, specified disease, hospital policies providing a fixed daily benefit only, Medicare supplement, long-term care, hospitalization-surgical, or any other supplemental policy determined by the DOI.		• Requires coverage to be subject to the same coinsurance, co-pay, deductible, annual maximum, and lifetime maximum factors as apply to physical illness. • Requires at least 2 sessions per year with a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within the scope of such license. ▪ Requires such coverage to be for diagnosis or assessment. ▪ Prohibits coverage from being subject to any pre-approval conditions. ▪ Requires the same coinsurance, co-pay, and deductible factors to apply to regular office visits for mental health benefits as for physical illnesses. **Benefit management of mental health coverage:** Permits mental health benefits to be offered through a managed care program. • Permits covered services to be delivered through a system of contractual arrangements with one or more providers, hospitals, residential or residential treatment programs. **Substance abuse mandated offer requirements:** Requires affected entities to offer coverage for chemical dependency. **Scope of substance abuse coverage:** Requires minimum coverage offerings to include: ▪ 26 days of outpatient treatment through a nonresidential treatment program or through partial or full day program services per benefit period; ▪ 21 days of inpatient residential treatment per benefit period; and ▪ 6 days of detoxification in a medical or social setting per benefit period. • Permits a separate lifetime cap of 10 episodes of treatment, except for medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within 48 hours of treatment to the reasonable satisfaction of the affected entity. • Requires coverage to be subject to the same coinsurance, co-payment, and deductible factors as those that apply to physical illness. **Benefit management of substance abuse coverage:** Permits substance abuse benefits to be offered through a managed care program. • Permits services to be delivered through a system of contractual arrangements with one or more providers, hospitals, residential or nonresidential treatment programs, or other mental health service delivery entities certified by the department of mental health or accredited by a nationally recognized organization, or licensed by the state.

State law	Applicability	Definitions	Major provisions
Missouri *Mo. Rev. Stat. §376.779* Effective 1995 Amended 2004	Individually underwritten health plans or policies which provide hospital treatment. Does not apply to supplemental insurance policies, including life, accident-only, specified disease, and hospital policies providing a fixed daily benefit only, Medicare supplement, long-term care, short-term major medical of less than 6 months.	No definitions.	**Substance abuse parity requirements:** Requires affected entities to provide coverage, while confided in a hospital or residential or nonresidential facility certified by the Department of Mental Health, for treatment for treatment of alcoholism on the same basis as for coverage for any other illness. **Scope of coverage:** Permits coverage to be limited to a total of 30 days in any policy or contract period for all levels of care.
Montana *Mont. Code Ann. §33-22-706 [as amended by S.B. 234 (2009)]* Effective 2000 Amended 2009	HMOs, individual and group health and disability insurers[3], individual and group hospital and medical expense insurers, medical subscriber contracts, membership contracts of a health service corporation, and the comprehensive health association. Does not apply to: • blanket, short-term travel, accident-	*"Severe mental illness"* means the following disorders as defined in the *DSM*: • schizophrenia; • schizoaffective disorder; • bipolar disorder; • major depression; • panic disorder; • obsessive-compulsive disorder; and • autism.	**Mental health parity requirements:** Requires affected entities to provide a level of benefits for the necessary care and treatment of severe mental illness that is no less favorable than that level provided for other physical illnesses generally. **Scope of coverage:** Requires benefits to include: ▪ inpatient hospital services; ▪ outpatient services; ▪ rehabilitative services; ▪ medication; and ▪ services rendered by certain licensed health care professionals (including licensed advanced practice RNs with prescriptive authority and specializing in mental health). • Requires benefits for severe mental illness to be included when determining maximum lifetime benefits, co-pays and deductibles. • Requires coverage for a child with autism who is 18 years of age or younger to comply with the mental health coverage parity requirements if the child is di-

[3] In Montana, health insurance is known as "disability insurance." For more information, see AHIP's *Disability Income Protection and Health Insurance: State Definitions* chart.

State law	Applicability	Definitions	Major provisions
	only, limited or specified disease policies; • individual conversion policies or contracts; or • policies or contracts designed for issuance to persons eligible for coverage under Medicare, or any other similar coverage under state or federal governmental plans.		agnosed with autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified. **Benefit management:** Permits benefits to be subject to managed care provisions contained in the policy or certificate.
Montana *Mont. Code Ann. §33-22-703* Effective 2001	Insurers, health service corporations, and all employees' health and welfare funds issuing accident and health group policies and certificates or group subscriber contracts. Does not apply to: • blanket, short-term travel, accident-only, limited or specified disease policies; • individual conversion policies or contracts; or • policies or contracts designed for issuance to persons	No definitions.	**Mental health and substance abuse coverage requirements:** Requires affected entities to provide for the necessary care and treatment of mental illness, alcoholism, and drug addiction. • Requires affected entities to provide for the necessary care and treatment of mental illness, alcoholism, and drug addiction, under major medical policies or contracts, inpatient and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors. **Scope of coverage:** Requires the following minimum coverage: • inpatient treatment for mental illness of 21 days annually; • inpatient treatment for mental illness may be traded on a 2:1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program as published by the American Association for Partial Hospitalization if the program is operated by a hospital; • inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, up to $6,000 annually until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000; • costs for medical detoxification treatment paid the same as any other illness; and • outpatient treatment under major medical of $2,000 annually.

State law	Applicability	Definitions	Major provisions
	eligible for coverage under Medicare, or any other similar coverage under state or federal governmental plans.		
Montana *Mont. Code Ann. §53-21-132* Effective 2005	Private insurance carriers and public assistance programs.	No definitions.	**Mental health coverage requirements:** Requires affected entities to provide coverage of the cost(s) associated with pre-commitment psychiatric detention, examination, and treatment for a person who is suffering from a mental disorder and who requires commitment to a mental health facility.
Nebraska *Neb. Rev. Stat. §44-769, et. seq.* Effective 1980	Insurers offering group sickness and accident insurance and HMOs.	"*Outpatient treatment*" means counseling and therapy provided on a nonresidential basis when such treatment is rendered in or through a hospital, a substance abuse treatment center, or an outpatient program which is certified or accredited to render such care.	**Substance abuse mandated offer requirements:** Requires affected entities that do not provide basic coverage for the treatment of alcoholism to notify consumers in written sales and advertising literature, descriptive brochures, and the exclusions provisions in the policy, contract or certificate that "This agreement does not provide basic coverage for the treatment of alcoholism. Coverage for treatment of alcoholism is available if you specifically request it and then only upon such terms and conditions as you and the company agree." • Prohibits the use of the term "comprehensive" in written sales and advertising literature, descriptive brochures, and the policy or contract. **Scope of coverage:** Requires benefits to be provided under such terms and conditions as may be agreed upon between the subscriber/insured and the insurer/HMO. • Deems the following benefits as providing basic coverage for the treatment of alcoholism if provided on terms involving durational limits, dollar limits, deductibles, and coinsurance which are no less favorable than the terms on which it makes benefits available for the treatment of physical illness generally: ▪ 30 inpatient days annually with at least 2 treatment periods in a lifetime; and ▪ 60 outpatient visits during the lifetime of the policy. • Prohibits co-pays, coinsurance, dollar or lifetime limits from being imposed that are less favorable generally than for physical illnesses.

State law	Applicability	Definitions	Major provisions
Nebraska *Neb. Rev. Stat. §44-791, et. seq.* Effective 2000	Group health insurance plans, group HMO contracts, group subscriber contracts, and any self-funded employee benefit plan, to the extent not preempted by federal law. • The term includes group policies, contracts, and/or plans offered or administered by the state or its political subdivisions. Does not apply to group policies providing coverage for a specified disease, accident-only coverage, hospital indemnity coverage, disability income coverage, Medicare supplement coverage, long-term care coverage, or other limited-benefit coverage. Does not apply to any plan covering an employer group with fewer than 15 employees.	*"Mental health condition"* means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Mental Disorders Section of the ICD. *"Rate, term, or condition"* means lifetime limits, annual payment limits, and inpatient or outpatient service limits. • Does not include any deductibles, co-pays, or coinsurance. *"Serious mental illness"* means any condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits life activities. Includes, but is not limited to: • schizophrenia; • schizoaffective disorder; • delusional disorder; • bipolar affective disorder; • major depression; and • obsessive compulsive disorder.	**Mental health parity requirements:** Does not require coverage for mental health conditions or serious mental illnesses. • Prohibits affected entities providing coverage for the treatment of mental health conditions other than alcohol or substance abuse, from establishing any rate, term or condition that places a greater financial burden on an insured for access to treatment of serious mental illness than for access to treatment for a physical health condition. ▪ If no coverage is provided for serious mental health conditions, requires benefit materials to contain a clear and prominently placed notice of such non-coverage. **Scope of coverage:** Requires out-of-pocket limits to be a single "comprehensive" limit for coverage of both mental health conditions and physical health conditions. • Requires health insurance plans providing coverage for serious mental illness to cover health care rendered for treatment of serious mental illness by a mental health professional, by a person authorized by DHHS Regulation and Licensure to provide treatment for mental illness, in a mental health center, or any other licensed institution or facility providing mental health treatment pursuant to a written plan. **Benefit management:** Permits affected entities to manage the benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental health conditions that are deemed to be medically necessary and clinically appropriate. • Allows for management of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental health conditions that are deemed to be medically necessary and clinically appropriate. • Permits an affected entity to use a case management program or managed care organization to evaluate, determine, and provide or arrange for medically necessary and clinically appropriate care and treatment of each person with a mental health condition or serious mental illness who is covered by the plan. • Allows affected entities to require a provider who renders services for serious mental illnesses to enter into a contract as a condition of providing benefits. • Provides that nothing prohibits an affected entity from providing separate reimbursement rates and service delivery systems, including, but not limited to, mental health carve-out programs even if the plan does not provide similar options for the treatment of physical conditions.

State law	Applicability	Definitions	Major provisions
			Out-of-network services: Does not require coverage for non-emergency services provided by out-of-network providers. **Rule of construction:** Clarifies that nothing requires an affected entity to provide the same rates, terms, or conditions between treatments for serious mental illnesses and preventive care. • Provides that an affected entity is not in violation of these requirements if the plan applies different rates, terms, and conditions or excludes entirely from coverage the following: ▪ marital, family, educational, developmental, or training services; ▪ care that is substantially custodial in nature; ▪ services and supplies that are not medically necessary or clinically appropriate; or ▪ experimental treatments.
Nevada *Nev. Rev. Stat. §§57.689B.036 and 57.695C.174* Effective 1998 Amended 1999	Group health insurers.	No definitions.	**Substance abuse parity requirements:** Requires affected entities to provide the same coverage for the treatment of the abuse of alcohol or drugs as for any other covered illness. **Scope of coverage:** Requires the following minimum benefits: ▪ treatment for withdrawal from the physiological effects of alcohol or drugs of $1,500 per calendar year; ▪ treatment for a patient admitted to a facility of $9,000 per calendar year; and ▪ counseling for a person, group or family who is not admitted to a facility of $2,500 per calendar year. • Permits benefits to be received in any facility for the treatment of abuse of alcohol or drugs which is certified by the health division or any hospital or other facility or facility for the dependent which is licensed by the health division, accredited by the Joint Commission on Accreditation of Hospitals and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities.
Nevada *Nev. Rev. Stat. §57-689B-0359*	Group health insurers. Does not apply to	*"Severe mental illness"* means any of the following mental illnesses that are biologically based	**Mental health coverage requirement:** Requires affected entities to provide coverage for the treatment of severe mental illness.

State law	Applicability	Definitions	Major provisions
Effective 2000	groups with fewer than 25 employees.	and for which diagnostic criteria are prescribed in the DSM-IV: • schizophrenia; • schizo-affective disorder; • bipolar disorder; • major depressive disorders; • panic disorder; and • obsessive-compulsive disorder.	**Scope of coverage:** Requires coverage for: ▪ 40 days of hospitalization as an inpatient per policy year; ▪ 40 visits of outpatient treatment per policy year, excluding visits for the management of medication; and ▪ two visits for partial or respite care per policy year, which may be substituted for each one unused day of hospitalization coverage. • Provides that the required coverage does not include benefits for psychosocial rehabilitation or care received as a custodial inpatient. • Prohibits any deductibles and co-pays required for the treatment of severe mental illness from being greater than 150% of the out-of-pocket expenses required to be paid for medical/surgical benefits. **Exemption for cost increases:** Allows affected entities to seek approval from the Commissioner for an exemption from these requirements if premiums charged for the policy, or a standard grouping of policies, increases by more than 2% as the result of providing the required coverage.
New Hampshire *N.H. Rev. Stat. Ann. §415.18-a* Effective 1993	Insurers offering group or blanket accident or health insurance providing benefits for medical or hospital expenses, and HMOs.	*"Mental or nervous conditions"* or *"mental illness and emotional disorders"* means mental disorders, as defined in the most recent edition of DSM, excluding those disorders designated by a "V Code" and those disorders designated as criteria sets and axes provided for further study in the DSM. The term does not include chemical dependency, including alcoholism.	**Mental health parity requirement:** Requires affected entities to provide coverage for expenses arising from the treatment of mental illnesses and emotional disorders at least as favorable as for other illnesses. • Requires affected entities to offer to each group the option of purchasing, for a separate and identifiable premium, additional coverage for expenses incurred as a result of treatment or counseling by a licensed clinical social worker. **Scope of coverage:** For coverage for mental illnesses and disorders under a non-major medical plan, requires benefits to be: ▪ subject to terms and conditions at least as favorable as those applicable to services for other illnesses; and ▪ provided in a ratio of benefits to the fees charged in substantially the same ratio as for other illnesses. • For coverage for mental illnesses and disorders under a major medical plan, requires: ▪ for outpatient services, a minimum of 15 hours; ▪ for all other services, at least $3,000 per year and $10,000 per lifetime; and ▪ for co-payments and deductibles, application of amounts no less favorable than those that apply for other illnesses. • Prohibits any policy provision that denies benefits for psychiatric or psycho-

State law	Applicability	Definitions	Major provisions
			logical services, including psychological examinations, solely because they are rendered to an insured or a dependent in compliance with the lawful order of any court of this state. **Substance abuse coverage requirements:** Requires policies covering mental illnesses and disorders to include coverage for expenses arising from treatment for chemical dependency, including alcoholism, up to a specified limit which may be defined in terms of a dollar amount or a maximum number of days or visits. • Requires such coverage to include both an inpatient and an outpatient benefit for detoxification and rehabilitation.
New Hampshire *N.H. Rev. Stat. Ann. §37.417-E:1* Effective 1995	Insurers offering group or blanket accident or health insurance, nonprofit health service corporations, and HMOs.	*"Mental illness"* means a clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. *"Mental illness"* includes the following biologically based mental illnesses, as defined in the most current edition of the DSM: • schizophrenia; • schizoaffective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders; • obsessive-compulsive disorder; • panic disorder; and • pervasive developmental disorder or autism.	**Mental health parity requirement:** Requires affected entities providing benefits for disease or sickness to provide benefits for treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and which are not less extensive than coverage provided for any other type of health care for physical illness.

State law	Applicability	Definitions	Major provisions
New Jersey *N.J. Stat. Ann. §17B:27-46.1* Effective 1985 Amended 1997	Insures offering group health insurance policies providing hospital or medical expense benefits.	No definitions.	**Substance abuse parity requirement:** Requires affected entities to provide coverage for expenses incurred in connection with the treatment of alcoholism when such treatment is prescribed by a doctor. • Requires such benefits to be provided to the same extent as for any other sickness under the contract. **Scope of coverage:** Requires such coverage to include inpatient or outpatient care in a licensed hospital that meets minimum standards of care equivalent to those prescribed by the Joint Commission on Accreditation of Hospitals, and treatment at a detoxification licensed facility.
New Jersey *N.J. Stat. Ann. §17B:27-46.1v* Effective 1999 Amended 2005 *N.J. Admin. Code §11:4-57.1 to 11:4-57.4* Readopted 2006	Insurers offering group health insurance policies providing hospital or medical expense benefits.	*"Biologically based mental illness"* means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: • schizophrenia; • schizo-affective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders; • obsessive-compulsive disorder; • panic disorder; and • pervasive developmental disorder or autism.	**Mental health parity requirements:** Requires affected entities to provide benefits for biologically based mental illness under the same terms and conditions with respect to co-payments, deductibles, or benefit limits as provided for any other sickness under the policy. • Prohibits affected entities from applying any exclusion or denying benefits for services or supplies that are medically necessary for the treatment of covered persons with biologically based mental illness, to the extent such services or supplies are not experimental or investigational. **Scope of coverage:** Prohibits exclusions or denials of benefits from including, but not limited to: ▪ treatment for chronic conditions; ▪ physical, speech and occupational therapy that is non-restorative; ▪ services rendered after a fixed period of time has elapsed from an injury, procedure, or the onset of illness; ▪ treatment of developmental disorders or developmental delay; ▪ therapy on a long-term basis; ▪ treatment of behavioral problems; and ▪ treatment of learning disabilities. • Requires affected entities to apply benefit limits, including preauthorization requirements and visit limits, to the treatment of biologically based mental illness to the same extent as those applied on physical illnesses. ▪ Permits visit limits to be applied for the treatment of biologically based mental illness if the same visit limits are applied to therapy for the treatment of physical illness.

State law	Applicability	Definitions	Major provisions
			○ For example, a limit of 30 speech therapy visits per year is permitted for speech therapy to treat a biologically based mental illness (such as autism or pervasive developmental disorder), if the limit also applies to speech therapy to treat a physical illness (such as stroke). ▪ Prohibits blanket preauthorization requirements of all services to treat biologically-based mental illness. ▪ Permits preauthorization of particular services for the treatment of biologically based mental illness only if preauthorization is required for the same or similar services when provided to treat physical illness. ○ For example, a carrier may require preauthorization of partial day hospitalization for the treatment of biologically based mental illness if it also requires preauthorization of intensive outpatient treatments for physical illness such as outpatient surgery, chemotherapy or radiation therapy. **Benefit management:** Allows insurers to continue usual procedures for determining the medical necessity of services. • Permits insurers to determine which providers are entitled to reimbursement for providing services for mental illnesses under the policy.
New Mexico *N.M. Stat. Ann. §59A-23-6* Effective 1983	Group health insurers.	No definitions.	**Substance abuse mandated offer requirements:** Requires covered entities to offer coverage and make available benefits for the necessary care and treatment of alcohol dependency with the same annual deductibles and coinsurance requirements for other benefits within the same policy. • Requires benefits to be subject to the rights of the group policyholder to reject the coverage of to select any alternative level of benefits. **Scope of coverage:** Requires coverage to include a minimum of 30 days of inpatient and outpatient treatment. • Requires benefits to be offered for benefit periods of no more than 1 year and prohibits a lifetime maximum of less than 2 benefit periods.
New Mexico *N.M. Stat. Ann. §59A-23E-18* Effective 2000	Group health plans.	*"Mental health benefits"* means mental health benefits as described by the group health plan offered in connection with the plan.	**Mental health parity requirements:** Requires affected entities to provide both medical/surgical benefits and mental health benefits. • Prohibits an affected entity from imposing treatment limitations or financial requirements on the provision of mental health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

State law	Applicability	Definitions	Major provisions
		• The term does not mean benefits with respect to substance abuse, chemical dependency, or gambling addiction.	**Benefit management:** Permits affected entities to: • require pre-admission screening prior to authorization of mental health benefits whether inpatient or outpatient; and • apply limitations that restrict mental health benefits provided under the plan to those that are medically necessary. **Exemption for cost increases:** If a policyholder with fewer than 50 employees experiences a premium increase of more than 1½%in a plan year due to the change in coverage or a policyholder with 50 or more employees experiences a premium increase of more than 2½ % in a plan year due to the change in coverage, the policyholder may either: • pay the premium increase excess; • reach agreement with the employees to cost-share that amount of the premium increase excess; • negotiate a reduction in coverage, but not below the coverage existing before the renewal to reduce the premium increase excess; or • after demonstrating that the amount of the excess premium is due exclusively to the additional coverage required, receive written permission from the division of insurance to not increase coverage.
New York *N.Y. Ins. Law §3221* Effective 2007 Sunsets 12/31/09	Insurers delivering a group or school blanket policy, hospital and health service corporations, and medical expense indemnity policies Mandatory provision of coverage does not apply to group purchasers with 50 or fewer employees. Group purchasers with 50 or fewer employees must offer the coverage required.	*"Biologically based mental illness"* means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. • Such biologically based mental illnesses are defined as: ▪ schizophrenia/psychotic disorders; ▪ major depression; ▪ bi-polar disorder; ▪ delusional disorders; ▪ panic disorders;	**Mental health parity requirements:** Requires affected entities to provide broad-based coverage for the diagnosis and treatment of mental, nervous, or emotional disorders or ailments, however defined in such policy, at least equal to coverage provided for other health conditions. • Requires affected entities providing coverage for inpatient hospital care or physician services to provide comparable coverage for care for adults and children with biologically based mental illness and children with serious emotional disturbance comparable to the medical coverage provided under the policy. **Scope of coverage:** Requires coverage for the diagnosis and treatment of mental, nervous, or emotional disorders or ailments to include benefits for inpatient care in a hospital. ▪ Permits such benefits to be limited to not less than 30 days of active treatment in any contract, plan, or calendar year. • Requires coverage for the diagnosis and treatment of mental, nervous, or emotional disorders or ailments to include outpatient care provided in a facility op-

State law	Applicability	Definitions	Major provisions
		▪ obsessive compulsive disorders; ▪ bulimia and anorexia. *"Children with serious emotional disturbances"* means persons under the age of 18 years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive developmental disorders, and where there are one or more of the following: • serious suicidal symptoms or other life-threatening self-destructive behaviors; • significant psychotic symptoms (hallucinations, delusional, bizarre behaviors); • behavior caused by emotional disturbances that placed the child at risk of causing persona injury or significant property damage; or • behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or • behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.	erating certificate by the commissioner of mental health, or in a facility operated by the office of mental health, or by a psychiatrist or psychologist licensed to practice in this state or a professional corporation or university faculty practice corporation. ▪ Permits benefits to be limited to not less than 20 visits in any contract, plan, or calendar year. • Allows partial hospitalization program benefits to offset covered inpatient days at a ratio of 2 partial hospitalization visits to 1 inpatient day. • Permits coverage for the diagnosis and treatment of mental, nervous, or emotional disorders or ailments to be subject to annual deductibles and co-insurance as may be deemed appropriate by the superintendent and as consistent with those imposed on other benefits within a given policy. • Requires coverage for biologically based mental illnesses and serious emotional disturbances to be provided under the terms and conditions otherwise applicable under the policy, including network limitations or variations, exclusions, co-pays, co-insurance, deductibles, or other specific cost-sharing mechanisms. • Permits coverage for biologically based mental illnesses and serious emotional disturbance through networks to have different co-insurance, co-pays, or deductibles for out-of-network benefits, regardless of whether the policy is written under one license or two. **Benefit management:** Nothing shall be construed as preventing the medical management or utilization review of mental health benefits, including the use of prospective, concurrent, or retrospective utilization review, preauthorization, and appropriateness criteria as to the level and intensity of treatment applicable to behavioral health. • Nothing shall be construed as preventing a policy from providing services through a network of participating providers who meet certain requirements for participation, including provider credentialing. **Cost report:** Requires the superintendent, in consultation with the office of mental health, to study the effectiveness of mental health parity. • Requires the study to be completed and sent to the legislature and governor and include, but not be limited to: ▪ a comprehensive analysis of the costs associated with providing coverage pursuant to this act; ▪ the number of policyholders and group contract holders which have elected to purchase other mental health coverage required to be made available pursuant to this act; and

State law	Applicability	Definitions	Major provisions
			▪ a comparison of the type and number of illnesses for which coverage has been provided during the study period.
North Carolina *N.C. Gen. Stat. §58-51-50* Effective 1985 Amended 1991	Group insurance or blanket accident and health insurers.	*"Chemical dependency"* means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.	**Substance abuse mandated offer requirements:** Requires affected entities to offer benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. • Requires a rejection of such offer to be in writing. **Scope of coverage:** Requires benefits for chemical dependency to be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness. • Requires contracts to provide for $8,000 worth of benefits for each 12-month period, and a lifetime minimum benefit of $16,000. • Requires coverage of the following providers: ▪ chemical dependency, medical, and psychiatric units in hospitals; ▪ chemical dependency units in psychiatric hospitals; ▪ residential chemical dependency treatment facilities; ▪ social setting detoxification facilities or programs; ▪ medical detoxification or programs; and ▪ licensed physicians, and duly licensed practicing psychologists.
North Carolina *N.C. Gen. Stat. §135-40.7B* Effective 2000	State employee benefit plans and CHIP.	*"Mental illness"* means: • with respect to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care supervision, guidance, or control; and • with respect to a minor, a mental health condition, other than mental retardation alone, that so impairs the	**Mental health and substance abuse parity requirements:** Requires benefits for mental illness and chemical dependency to be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illnesses generally. **Scope of coverage:** Requires affected entities to provide coverage for institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment. • Establishes a list of facilities in which mental illness and chemical dependency treatment may be provided. Provides a list of the providers who may provide necessary care and treatment of mental illness and chemical dependency. **Benefit management:** Requires mental illness and chemical dependency benefits to be subject to case management programs for medical necessity and appropriateness.

State law	Applicability	Definitions	Major provisions
		youth's capacity to exercise age adequate self-control or judgment in conduct of his/her activities and social relationships so that he/she is in need of treatment. *"Chemical dependency"* means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.	
North Carolina *N.C. Gen. Stat. §§58-51-55; 58-65-90; and 58-67-70, 58-67-75, and 122C-3(21)* Effective 1989 Amended 2007	Any group insurance contracts; hospital, medical and dental service corporations, and HMOs.	*"Mental illness"* means: • when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control; and • when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities and social relationships so that he is in need of treat-	**Mental health and substance abuse coverage requirements:** Prohibits affected entities from taking the below actions solely because an individual to be insured has or had a mental illness or chemical dependency: ▪ refuse to issue or deliver to that individual any policy that affords benefits or coverages for any medical treatment or service for physical illness or injury; ▪ have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or ▪ reduce physical illness or injury coverages or benefits for that individual. • Does not require affected entities to offer coverage for chemical dependency. • Prohibits HMOs providing mental health benefits from imposing a lesser lifetime or annual dollar limitation on such benefits than on physical illness or injury benefits.

State law	Applicability	Definitions	Major provisions
		ment, with a mental disorder defined in the DSM, except those mental disorders coded in the DSM as substance related, as sexual dysfunctions, and those coded as "V" codes. "*Chemical dependency"* means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal, with a mental disorder defined in the DSM.	
North Carolina *N.C. Gen. Stat. §§58-3-220 and 58-50-155* Effective 2008	Group health benefit plans and standard health plans offered to small employers	*"Mental illness"* means • when applied to an adult, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control; and • when applied to a minor, a mental condition, other than mental retardation alone, that so impairs the youth's capacity to exercise age adequate self-control or judgment in the conduct of his activities	**Mental health parity requirements:** Requires affected entities to provide coverage for the necessary care and treatment of mental illnesses that are no less favorable than those for physical illness, including limits to coverage. **Scope of coverage:** Requires affected entities to provide coverage for 30 combined inpatient and outpatient days per year as well as 30 office visits per year. • Permits durational limits on mental illnesses that differ from durational limits on physical illnesses, except for the following mental illnesses: ▪ bipolar disorder; ▪ major depressive disorder; ▪ obsessive compulsive disorder; ▪ paranoid and other psychotic disorders; ▪ schizoaffective disorder; ▪ schizophrenia; ▪ post-traumatic stress disorder; and ▪ anorexia and bulimia. • Permits annual limits, lifetime limits, co-pays, deductibles, or coinsurance be made applicable to the mental health benefits based on a weighted average of the benefits provided for physical health benefits when the affected entity has

State law	Applicability	Definitions	Major provisions
		and social relationships so that he is in need of treatment. "*Mental disorder*" means disorders defined in the most recent edition of the DSM, except those mental disorders coded as substance-related disorders , those coded as sexual dysfunctions , and those coded as 'V' codes. "*Limits*" includes deductibles, coinsurance, co-pays, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.	annual limits, lifetime limits, co-pays, deductibles, or coinsurance only on selected physical illness and injury benefits that do not represent substantially all of the physical benefits of the plan. • Exempts the affected entities insurers from providing coverage for treatment or studies leading to or in connection with sex changes or modifications and related care. **Benefit management:** Permits the affected entity to apply utilization review criteria to determine medical necessity.
North Dakota *N.D. Cent. Code §26.1-36-09* Effective 2000 Amended 2007	HMOs, insurance companies, and non-profit health service corporations in the group market.	No definitions.	**Mental health parity requirements:** Requires affected entities to provide the same type of benefits for mental health disorders as it does for other illnesses, which meet or exceed the benefits described below. **Scope of coverage:** Requires a minimum benefit for inpatient treatment of 45 days per calendar year. • Requires partial hospitalization or residential treatment for a minimum of 120 days in any calendar year. Allows any individual requiring more than the 120 calendar days of residential treatment to trade up to 23 days of unused inpatient treatment benefits. • Requires outpatient treatment for a minimum of 30 hours in any calendar year if provided by specified providers. Prohibits application of a deductible or co-payment for the first five hours and a co-payment greater than 20% for the remaining hours (unless services are provided by an out-of-network provider without a referral). • Requires an affected entity to provide coverage for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury. **Benefit management:** Allows an insurer to require "an individualized treatment

State law	Applicability	Definitions	Major provisions
			plan" from the inpatient provider which indicates that inpatient treatment is the most appropriate and least restrictive form of treatment available in the community."
North Dakota *N.D. Cent. Code §26.1-36-08* Effective 2001	An insurance company, nonprofit health service corporation, or HMO issuing group health coverage.	*"Substance abuse"* means alcoholism, drug addiction, or other related illnesses.	**Substance abuse coverage requirements:** Prohibits affected entities from delivering, issuing, executing, or renewing any health insurance policy or contract unless the policy or contract provides benefits, of the same type offered for other illnesses for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness, which benefits meet or exceed the benefits provided below. **Scope of coverage:** Requires affected entities to provide the following minimum coverage: ▪ 60 days of inpatient treatment in any calendar year if provided by a hospital offering substance abuse treatment; ▪ 120 days of partial hospitalization in any calendar year by a hospital (or similar center) providing substance abuse treatment; and ▪ 20 outpatient visits treatment in any calendar year when services are provided by a licensed physician (within his or her scope of practice), a licensed psychologist, or by a licensed addiction counselor with no deductible or co-payment for the first five outpatient visits in any calendar year and no co-payments of more than 20% for the remaining visits (unless services are provided by an out-of-network provider without a referral); and ▪ 60 days of residential treatment in any calendar year by a licensed residential treatment facility; however, permits unused inpatient treatment to be traded for residential treatment (generally, two days of residential treatment equals one day of inpatient, up to 23 days). • Permits benefits to be provided for a combination of inpatient and partial hospitalization with each day of inpatient treatment being equal to 2 days of partial hospitalization treatment (not to exceed 46 days of inpatient for partial hospitalization).
Ohio *Ohio Rev. Code Ann. §3923.27* Effective 1976	Policies of sickness and accident insurance, including both individual and group policies, that provides hospitalization	No definitions.	**Mental health coverage requirements:** Prohibits affected policies that provide hospitalization coverage for mental illness shall exclude such coverage for the reason that the insured is hospitalized in an institute or facility receiving tax support from the state, any municipal corporation, county, or joint county board, where such institution or facility is deemed charitable or otherwise, provided the institu-

State law	Applicability	Definitions	Major provisions
Amended 2005	coverage for mental illness.		tion or facility is fully accredited by the Joint Commission on Accreditation of Hospitals or certified under federal law. **Scope of coverage:** Requires payment in an amount equal to the lesser of either the full amount of the statutory charge for the cost of the services pursuant to §5121.33 of the Revised Code (governing the Department of Mental Health's liability for community health services) or the benefits payable for the services under the applicable policy. • Requires benefits to be paid so long as patients and their liable relatives remain responsible for payment under state law. • Limits payment to that portion or percent of the benefits that have been assigned, or ordered to be paid, to the state or other appropriate provider for services rendered by the institution or facility.
Ohio *Ohio Rev. Code Ann. §3923.28* Effective 1980 Amended 2006	Group policies of sickness and accident insurance. Does not apply to policies providing coverage for specific diseases or accidents only.	No definitions.	**Mental health coverage requirements:** Requires affected policies that provide coverage for mental or emotional disorders to include benefits for services on an outpatient basis for each eligible person under the policy who resides in this state for mental or emotional disorders or for evaluations. **Scope of coverage:** Mandates benefits that are at least equal to $550 in any calendar year. • Requires the services to be legally performed by or under clinical supervision of a licensed physician, licensed osteopath, licensed psychologist, licensed professional clinical counselor, licensed professional counselor, licensed independent social worker, licensed clinical nurse specialist whose nursing specialty is mental health. • Mandates coverage whether performed in an office, in a hospital, or in a community mental health facility so long as the hospital or community mental health facility is approved by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation for Children and Family Services, the Rehabilitation Accreditation Commission, or certified by the Department of Mental Health as being in compliance with standards established under state law. • Allows the benefits to be subject to reasonable contract limitations and may be subject to reasonable deductibles and co-insurance costs. • Limits benefits for persons entitled to coverage under more than 1 insurance contract to a single $550 outpatient benefit.

State law	Applicability	Definitions	Major provisions
			Benefit management: States that in order to be reimbursable, services provided must comply with the following requirements: • the services must be performed in accordance with a treatment plan that describes the expected duration, frequency, and type of services to be performed; • the treatment plan shall be reviewed and approved by the health care professional every 3 months. **Rule of Construction:** Provides that nothing shall be construed to require an insurer to pay benefits which are greater than usual, customary, and reasonable. • States that the required benefits shall not be reduced by the cost of benefits required under §3923.281 (see below) for the diagnosis and treatment for biologically based mental illnesses. • Clarifies that these requirements do not apply to benefits for the diagnosis and treatment of biologically based mental illness.
Ohio *Ohio Rev. Code Ann. §3923.281* Effective 2007 Amended 2008	Policies of sickness and accident insurance Does not apply to long-term care, hospital indemnity, disability income, Medicare supplement plans, one-time limited duration policies of no longer than 6 months, workers' compensation, Medicaid, or any policy that provides coverage to beneficiaries enrolled in the children's buy-in program established under state law.	*"Biologically based mental illness"* means the following as defined in the most recent edition of the DSM: • schizophrenia; • schizoaffective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders; • obsessive-compulsive disorder; and • panic disorder.	**Mental health parity requirements:** Requires coverage for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, with benefits no less extensive than, those provided for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply: • the biologically based mental illness is clinically diagnosed by a licensed physician authorized to practice medicine and surgery or osteopathic medicine and surgery; a licensed psychologist; a licensed professional clinical counselor, licensed professional counselor, or licensed independent social worker; or a licensed clinical nurse specialist whose nursing specialty is mental health; and • the prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards. **Scope of coverage:** Applies the parity requirements to all policy terms and conditions, including, but not limited to: coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles. **Benefit management:** Provides that nothing prohibits insurers from taking or pursuing the following actions: • negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services; and/or • managing the provision of benefits for the diagnosis or treatment of biological-

State law	Applicability	Definitions	Major provisions
			ly based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary. **Exemption for cost:** Provides an exemption from the coverage requirements if all of the following apply: • the insurer submits documentation certified by an independent member of the American Academy of Actuaries to the DOI showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least 6 months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than 1% per year; • the insurer submits a signed letter from an independent member of the American Academy of Actuaries to the DOI opining that the increase described above could reasonably justify an increase of more than 1% in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders; and • the Superintendent of Insurance makes the following determinations from the documentation and opinion submitted: ▪ incurred claims for services for biologically based mental illnesses for a period of at least 6 months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than 1% per year; and ▪ the increase in costs reasonably justifies an increase of more than 1% in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.
Ohio *Ohio Rev. Code Ann. §3923.282* Effective 2007	Any private or public employer group self-insurance plan that provides payment for health care benefits for other than specific diseases or accidents only, which benefits are not provided by contract with a sickness and ac-	*"Biologically based mental illness"* means the following as defined in the most recent edition of the DSM: • schizophrenia; • schizoaffective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders;	**Mental health parity requirements:** Requires coverage for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, with benefits no less extensive than, those provided for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply: • the biologically based mental illness is clinically diagnosed by a licensed physician authorized to practice medicine and surgery or osteopathic medicine and surgery; a licensed psychologist; a licensed professional clinical counselor, licensed professional counselor, or licensed independent social worker; or a licensed clinical nurse specialist whose nursing specialty is mental health; and • the prescribed treatment is not experimental or investigational, having proven

State law	Applicability	Definitions	Major provisions
	cident insurer or health insuring corporation. Does not apply if federal law supersedes, preempts, prohibits, or otherwise precludes its application to employer group self-insurance plans. Does not apply to long-term care, hospital indemnity, disability income, or Medicare supplement plans of health coverage, or to any other supplemental benefit plans.	• obsessive-compulsive disorder; and • panic disorder.	its clinical effectiveness in accordance with generally accepted medical standards. **Scope of coverage:** Applies the parity requirements to all policy terms and conditions, including, but not limited to: coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles. **Benefit management:** Provides that nothing prohibits employers from taking or pursuing the following actions: • negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services; and/or • managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary. **Exemption for cost:** Provides an exemption from the coverage requirements if all of the following apply: • the employer submits documentation certified by an independent member of the American Academy of Actuaries to the DOI showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least 6 months independently caused the employer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than 1% per year; and • the Superintendent of Insurance determines that incurred claims for services for biologically based mental illnesses for a period of at least 6 months independently caused the employer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than 1% per year.
Ohio *Ohio Rev. Code Ann. §3923.29* Effective 1978 Amended 2001	Group policies of sickness and accident insurance. Does not apply to policies that provide cover-	No definitions.	**Substance abuse coverage requirements:** Requires coverage for each eligible person under the policy who resides in the state for outpatient, inpatient, and intermediate primary care benefits for alcoholism. **Scope of coverage:** Mandates that coverage is provided in an amount that is at least equal to $550 in any calendar year or twelve month period.

State law	Applicability	Definitions	Major provisions
	age for specific diseases or accidents only.		• Requires the services to be legally performed by or under the clinical supervision of a licensed physician or a licensed psychologist. • Mandates coverage whether performed in an office, in a hospital, in a community mental health facility, or in an alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the Joint Commission on Accreditation of Hospitals or certified by the Department of Health. • Allows the mandated benefits to be subject to reasonable contract limitations and may be subject to reasonable deductibles and co-insurance costs. • Limits benefits for persons entitled to coverage under more than 1 insurance contract to a single $550 benefit. **Benefit management:** Requires a licensed physician or a licensed psychologist to certify every 3 months that the patient needs to continue utilizing such treatment for a patient who receives treatment for alcoholism from an approved or certified alcoholism treatment facility to remain entitled to the mandated benefits. **Rule of Construction:** Provides that nothing shall be construed to require an insurer to pay benefits which are greater than usual, customary, and reasonable.
Ohio *Ohio Rev. Code Ann. §3923.30* Effective 1978 Amended 2006	Every person, the state and any of its instrumentalities, any county, township, school district, or other political subdivisions and any of its instrumentalities, and any municipal corporation and any of its instrumentalities, which provides payment for benefits for any of its employees resident in this state, which benefits are not provided by contract with an insurer qualified to provide sickness and accident	No definitions.	**Mental health coverage requirements:** Requires affected policies that provide coverage for mental or emotional disorders to include benefits for services on an outpatient basis for each eligible person under the policy who resides in this state for mental or emotional disorders or for evaluations. **Scope of coverage for mental health benefits:** Mandates benefits that are at least equal to $550 in any calendar year. • Requires the services to be legally performed by or under clinical supervision of a licensed physician, licensed osteopath, licensed psychologist, licensed professional clinical counselor, licensed professional counselor, licensed independent social worker, licensed clinical nurse specialist whose nursing specialty is mental health. • Mandates coverage whether performed in an office, in a hospital, or in a community mental health facility so long as the hospital or community mental health facility is approved by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation for Children and Family Services, the Rehabilitation Accreditation Commission, or certified by the Department of Mental Health as being in compliance with standards estab-

State law	Applicability	Definitions	Major provisions
	insurance, or a health insuring corporation.		lished under state law. • Allows the benefits to be subject to reasonable contract limitations and may be subject to reasonable deductibles and co-insurance costs. • Limits benefits for persons entitled to coverage under more than 1 insurance contract to a single $550 outpatient benefit. **Benefit management for mental health coverage:** States that in order to be reimbursable, services provided must comply with the following requirements: • the services must be performed in accordance with a treatment plan that describes the expected duration, frequency, and type of services to be performed; • the treatment plan shall be reviewed and approved by the health care professional every 3 months. **Rule of construction:** Provides that nothing shall be construed to require an insurer to pay benefits which are greater than usual, customary, and reasonable. • States that the required benefits shall not be reduced by the cost of benefits required under §3923.281 (see below) for the diagnosis and treatment for biologically based mental illnesses. • Clarifies that these requirements do not apply to benefits for the diagnosis and treatment of biologically based mental illness. **Substance abuse parity requirements:** Requires payment for benefits for alcoholism treatment for outpatient, inpatient, and intermediate primary care for each eligible employee and dependent **Scope of coverage for substance abuse benefits:** Mandates that benefits provided are no less than $550 in a 12 month period. • Requires the services to be legally performed by or under clinical supervision of a licensed physician, licensed osteopath, licensed psychologist, licensed professional clinical counselor, licensed professional counselor, licensed independent social worker, licensed clinical nurse specialist whose nursing specialty is mental health. • Mandates coverage whether performed in an office, or in a hospital or a community mental health facility or alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the Joint Commission on Accreditation of Hospitals or certified by the Department of Health. • Permits the benefits to be subject to reasonable limitations and may be subject to reasonable deductibles and co-insurance costs.

State law	Applicability	Definitions	Major provisions
			Benefit management: Requires a health care professional to certify every 3 months the patient's need for continued services performed by such facilities.
Oklahoma *Okla. Stat. §§36-6060.10 through 36-6060.12* Effective 2000	Health benefit plans including: group hospital or medical insurance coverage; not-for-profit hospital or medical service indemnity plans; prepaid health plans; HMOs; PPOs; state and education employees group insurance plans; MEWAs; and employer self-insured plans not exempt under ERISA. Does not apply to small employers (50 or fewer full-time employees). Does not apply to individual, specified disease, accidental death or dismemberment, Medicare supplement, workers compensation, long-term care, motor vehicle, or nursing home fixed indemnity policies.	*"Severe mental illness"* means any of the following biologically based mental illness as defined in DSM: • schizophrenia; • bipolar disorder (manic depressive illness); • major depressive disorder; • panic disorder; • obsessive-compulsive disorder; and • schizoaffective disorder.	**Mental health parity requirements:** Requires a health benefit plan providing benefits for the treatment of severe mental illness. • Requires benefits to be equal to benefits for treatment for all other physical diseases and disorders, including but not limited to those listed below. **Scope of coverage:** Requires coverage for treatment of severe mental illness to include but not be limited to: • coverage of inpatient hospital services for either 26 days or the limit for other covered illnesses (whichever is greater); • coverage of outpatient services; • coverage of medication; • maximum lifetime benefits; • co-pays; • coverage of home health visits; • individual and family deductibles; and • coinsurance. **Benefit management:** Requires coverage of severe mental illness to be subject to the same pre-authorization and utilization review mechanisms and other terms and conditions as all other physician diseases and disorders. **Exemption for cost increases:** Exempts a health benefit plan from mental health coverage requirements, if, as calculated under a specified formula, the plan experiences a greater than two percent increase in premium costs for provided the required coverage. **Penalties:** Imposes penalties (including suspension, loss of license, or any other penalty as determined by the state) on plans if the commissioner finds that a plan's request for exemption is provided under knowingly false information.
Oregon *Or. Rev. Stat.*	Group health insurers, health care service con-	*"Chemical dependency"* means the addictive relationship with	**Mental health and substance abuse coverage requirements:** Requires affected entities providing coverage for hospital or medical expenses to also provide cover-

State law	Applicability	Definitions	Major provisions
§743-556 Effective 2001 Amended 2007	tractors, and HMOs providing coverage for hospital or medical expenses.	any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems. The term does not include addiction to, or dependency on tobacco, tobacco products, or foods. *"Mental or nervous conditions"* are not defined.	age for expenses arising from treatment for chemical dependency including alcoholism and mental or nervous conditions. **Scope of coverage:** Permits coverage to be subject to provisions that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. • Prohibits deductible and coinsurance for treatment in health care facilities or residential programs or facilities from being greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. • Prohibits deductibles and coinsurance for outpatient treatment from being greater than those under the policy for expenses of outpatient treatment of other medical conditions. • Prohibits deductibles and coinsurance for treatment in health facilities or residential programs or facilities, or outpatient treatment from being greater than those under the policy for expenses of such coverage in treatment of physical illness. • Permits benefits to be provided by: ▪ programs or providers approved by the office of Alcohol and Drug Abuse Programs or by the Mental Health and Developmental Disability Services Division; programs accredited for such care by Joint Commission on Accreditation of Hospitals; and ▪ licensed inpatient programs, residential, outpatient, or day or partial hospitalization programs. • Prohibits payments for chemical dependency together with any kind of mental or nervous condition from being less than $13,125 for adults and $15,625 for children. • Prohibits payments of less than less than $8,125 for adults and $13,125 for children when requesting treatment for chemical dependency but not for any kind of mental or nervous condition. • Prohibits coverage from being subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. • Permits an insured to receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation. • Permits, if specified in the policy, outpatient coverage to include follow-up in-home service or outpatient services. ▪ Permits the policy to limit coverage for in-home service to persons who

State law	Applicability	Definitions	Major provisions
			are homebound under the care of a physician. • Does not require coverage for: ▪ educational or correctional services or sheltered living provided by a school or halfway house; ▪ a long-term residential mental health program that lasts longer than 45 days; ▪ psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; ▪ a court-ordered sex offender treatment program; or ▪ a screening interview or treatment program. **Benefit management:** Permits coverage of eligible expenses to be limited to treatment that is medically necessary as determined under the policy for other medical conditions. • Does not require affected entities to contract with all eligible providers. • Permits HMOs to limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the HMO. • Permits a group health insurer to manage of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those outlined. • Subject to the patient or client confidentiality provisions of physicians, nurse practitioners, psychologists, and licensed clinical social workers, permits affected entities to provide for review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who must have the authority to certify for or deny level of payment. • Permits review to involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, requires provisions to be made to allow for payment of urgent or emergency admissions, subject to subsequent review. ▪ If prior approval is not required, requires affected entities to permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Requires affected entities to provide a timely response

State law	Applicability	Definitions	Major provisions
			to such inquiries. **Out-of-network services:** Requires affected entities to pay benefits toward the covered charges of non-contracting providers for the treatment of chemical dependency or mental or nervous conditions. • Gives the insured the right to use the services of a non-contracting provider for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or non-contracting providers.
Pennsylvania *Pa. Cons. Stat. §40.908-1, et. seq.* Effective 1989	Health insurers, hospital plan corporations, professional health services plan corporations, and HMOs issuing group health or sickness and accident insurance policies. Does not apply to Medicare or Medicaid supplemental contracts or limited coverage accident and sickness policies.	*"Alcohol and drug abuse"* means any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.	**Substance abuse coverage requirements:** Requires affected entities to provide treatment for alcoholism and drug addiction. **Scope of coverage:** Requires coverage for: • 7 days of inpatient detoxification services annually, with 28 days per lifetime; • 30 outpatient visits annually, with 120 days per lifetime; • 30 partial/residential days annually, with 90 days per lifetime; and • a course of treatment under a prospective payment plan with application of the same deductible or co-payment as applied to similar classes or categories of treatment for physical illness.
Pennsylvania *Pa. Cons. Stat. §40.6-764* Effective 1999	Group health policies issued to groups of 50 or more employees. Does not include the following policies: accident only; fixed indemnity; limited benefit; credit; dental; vision; specified disease; Medicare supplement;	*"Serious mental illness"* means any of the following mental illnesses as defined in the most recent DSM: • schizophrenia; • bipolar disorder; • obsessive-compulsive disorder; • major depressive disorder; • panic disorder; • anorexia nervosa;	**Mental health coverage requirements:** Requires affected entities to provide coverage for serious mental illnesses. **Scope of coverage:** Requires coverage to: • provide at least 30 inpatient days and 60 outpatient days annually (which can be converted on a one for two basis for inpatient/outpatient days); • have no differences between annual or lifetime dollar limits in coverage for serious mental illness and any other illnesses; and • not prohibit access to care by imposing cost sharing arrangements, including, but not limited to, deductibles and co-pays for coverage of serious mental illnesses.

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	CHAMPUS supplement; long-term care; or disability income.	• bulimia nervosa; • schizoaffective disorder; and • delusional disorder.	**Cost report:** Requires the Legislative Budget and Finance Committee to study the cost and benefits of the requirements and make a report to the General Assembly every two years.
Rhode Island *R.I. Gen. Laws §7-38-1* Effective 1989	Health insurers.	*"Substance dependency and abuse"* means the pattern of pathological use of alcohol or other psychoactive drugs characterized by impairments in social and/or occupational functioning, debilitating physical condition, inability to abstain from or reduce consumption for the substance, or the need for daily substance use for adequate functioning.	**Substance abuse coverage requirements:** Requires insurers to provide coverage for services relating to medically necessary treatment for substance dependency and abuse. **Scope of coverage:** Requires coverage to include: • 30 hours of outpatient treatment annually furnished in a licensed state hospital; • 3 detoxification occurrences or 21 days annually (whichever comes first); and • 30 days of intensive rehabilitation services annually with at lifetime benefit per patient of 90 days for intensive rehabilitation.
Rhode Island *R.I. Gen. Laws §27-38.2-1, et. seq.* Effective 1995	Health insurers. Does not apply to hospital confinement indemnity, disability income, accident only, long-term care, Medicare supplement, limited benefit health, specific disease indemnity, sickness or bodily injury or death by accident or both, or other limited benefit policies, or government programs.	*"Mental illness"* means any mental disorder and substance abuse disorder that is listed in the most recent edition of the DSM or ICD and that substantially limits the life activities of the person with the illness. • The term does not include tobacco and caffeine in the definition of "substance." • The term does not include mental retardation, learning disorders, motor skills disorders, communication disorders, and mental disorders classified as "V" codes.	**Mental health and substance abuse parity requirements:** Requires affected entities to provide coverage for the medical treatment of serious mental illness and substance abuse under the same terms and conditions as coverage provided for other illnesses and diseases. **Scope of coverage:** Requires coverage to include the same durational and amount limits, deductibles, and coinsurance for serious mental illness as for other illnesses and diseases. • Requires the following minimum requirements: ▪ outpatient services, with the exception of outpatient medication visits, for up to 30 visits in any calendar year; ▪ outpatient services for substance abuse treatment for up to 30 hours in any calendar year; ▪ community residential care services for substance abuse treatment for up to 30 days in any calendar year; and ▪ detoxification benefits for up to 5 detoxification occurrences or 30 days in any calendar year, whichever comes first. • Requires mental health benefits to be delivered in the state, unless it can be established through a pre-authorization process that the required services are not available in the state from a provider in the insurer's network.

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			Benefit management: Requires, upon request of the reimbursing health insurer, all providers of treatment of mental illness to furnish medical records or other necessary data which substantiates that initial or continued treatment is at all times medically necessary and appropriate. • Provides that a health insurer or patient is not obligated to reimburse for care when providers cannot establish the medical necessity and/or appropriateness of the treatment being provided. • Requires health insurers to make medical necessity or appropriateness determinations in a manner consistent with that used to make determinations for other treatments of other diseases or injuries.
South Carolina *S.C. Code. Ann. §38-71-737* Effective 1994	Group health insurers.	*"Psychiatric conditions"* means those mental and nervous conditions, drug and substance addition or abuse, alcoholism, or other conditions that are defined, described, or classified as psychiatric disorders or conditions in the most current publication of the DSM.	**Mental health mandated offer requirements:** Requires affected entities to offer an optional rider or endorsement for minimum psychiatric conditions. **Scope of coverage:** Imposes minimum benefits of at least $2,000 annually with a lifetime maximum benefit of $10,000. • Permits coverage to contain provisions prescribing different benefits for psychiatric conditions and physical conditions with respect to any deductible amount, coinsurance provision, or contract term affecting benefit determinations based upon use or nonuse of preferred providers.
South Carolina *S.C. Code Ann. §38-71-880* Effective 1997	Group health plans providing medical/surgical and mental health benefits. Does not apply to small employers with 1-50 employees.	*"Mental health benefits"* means those as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse.	**Mental health parity requirements:** Prohibits affected entities from imposing different aggregate lifetime and annual dollar limits, number of visits/days, cost sharing, and medical necessity requirements on mental health benefits different than those for medical/surgical benefits.
South Carolina *S.C. Code Ann. §1-11-760* Effective 2002	State health insurance plan.	*"Mental health condition"* means the following mental or nervous conditions that are caused by a biological disorder of the brain and results in a clinically signifi-	**Mental health and substance abuse coverage requirements:** Requires the state health insurance plan to provide coverage for the medically necessary treatment of a mental health condition and alcohol or substance abuse. **Scope of coverage:** Prohibits the establishment of any terms or conditions that

State law	Applicability	Definitions	Major provisions
Amended 2005		cant or psychological syndrome or pattern that substantially limits the functioning of the person with that illness: • schizophrenia; • schizoaffective disorder; • major depressive disorder; • bipolar disorder; • pervasive developmental disorder or autism; • panic disorder; • obsessive-compulsive disorder; • social anxiety disorder; • anorexia and bulimia; • Asperger's disorder; • intermittent explosive disorder; • post-traumatic stress disorder; • psychosis not otherwise specified when diagnosed in a child under 17 years old; • Rett's disorder; or • Tourette's disorder. *"Alcohol and substance abuse"* means any condition or disorder involving alcohol or substance abuse that falls under any of the categories listed in the DSM.	place a greater financial burden on an insured for access to treatment for a mental health condition or alcohol or substance abuse than for access to treatment for a physical health condition. • Requires any deductible or out-of-pocket limits to be comprehensive for coverage of all conditions. **Benefit management:** If the state health insurance plan does not otherwise provide for management of care or does not provide the same degree of management for all health conditions, it may provide management for medically necessary treatment of mental health and alcohol or substance abuse as long as the management does not diminish or negate the above requirements. • Requires care management to ensure that: ▪ timely and appropriate access to care is available; ▪ the quantity, location, and specialty distribution of health care providers is adequate; and ▪ administrative or clinical protocols do not reduce access to medically necessary treatment.
South Carolina *S.C. Code Ann. §38-71-290* Effective 2006	Health insurance plans, defined as a health insurance policy or health benefit plan offered by a health insurer or an	*"Mental health condition"* means the following psychiatric illnesses as defined in the DSM: • bipolar disorder; • major depressive disorder;	**Mental health parity requirements:** Requires affected entities to provide coverage for treatment of a mental health condition. • Prohibits the imposition of any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition in similar set-

State law	Applicability	Definitions	Major provisions
	HMO, including a qualified health benefit plan offered or administered by the State, or a subdivision or instrumentality of the State, that provides health insurance coverage.	• obsessive compulsive disorder; • paranoid or other psychotic disorder; • schizoaffective disorder; • schizophrenia; • anxiety disorder; • post-traumatic stress disorder; and • depression in childhood and adolescence.	tings and treatment modalities. **Scope of coverage:** Requires any deductible or out-of-pocket limits required under a health insurance plan to be comprehensive for coverage of both mental health and physical health conditions. • Requires treatment of mental illness to be rendered by a licensed physician, licensed mental health professional, or certified mental health professional in a mental health facility that provides a program for the treatment of a mental health condition pursuant to a written treatment plan. **Benefit management:** Permits affected entities that do not otherwise provide for management of care under the plan, or that do not provide for the same degree of management of care for all health conditions, to provide coverage for treatment of mental health conditions through a managed care organization if the organization is in compliance with state regulations.
South Dakota *S.D. Codified §58-18-80* Effective 1999	Group health insurers. Does not apply to coverage limited to a specified disease or covered benefit.	*"Biologically based mental illness"* means: • schizophrenia and other psychotic disorders; • bipolar disorder; • major depression; and • obsessive-compulsive disorder.	**Mental health parity requirements:** Requires affected entities to provide coverage for the treatment and diagnosis of biologically based mental illnesses with the same dollar limits, deductibles, coinsurance factors, and restrictions as other covered illnesses.
South Dakota *S.D. Codified §58-18-7.1* Effective 1979	Group and blanket health insurers.	No definitions.	**Substance abuse mandated offer requirements:** Requires affected entities to offer coverage for the inpatient treatment of alcoholism in licensed hospitals and residential primary treatment facilities approved in South Dakota which are carrying out an approved program pursuant to diagnosis and recommendation of a doctor. **Scope of coverage:** Requires coverage to include: • 30 days of inpatient, outpatient, and partial/residential care every 6 months, up to 90 days in a lifetime; and • the same co-pays, coinsurance, and lifetime dollar limits as for other illnesses.
Tennessee	Group health plans is-	"*Aggregate lifetime limit*" means	**Mental health coverage requirements:** Requires affected entities to provide cov-

State law	Applicability	Definitions	Major provisions
Tenn. Code Ann. §56-7-2360 Effective 2000	sued by entities regulated under the state insurance code. Does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit hospital insurance policies. Does not apply to small employers with 2-25 employees. Does not apply to individual policies.	a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit. "*Annual limit*" means a dollar limitation on the total amount that may be paid for benefits in a 12-month period under a health plan with respect to an individual or other coverage unit. "*Medication management"* means pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.	erage for mental health services as outlined below. **Scope of coverage:** If a group health plan provides both medical/surgical benefits and mental health benefits, allows the plan to impose aggregate lifetime limits or annual limits as follows: ▪ if the plan places no limit on substantially all medical/surgical benefit, the plan may place no limit on mental health benefits; ▪ if the plan places limit on substantially all medical/surgical benefits, the plan may include mental health benefits under the limit or apply a separate limit no less than the one applied to medical/ surgical benefits; or ▪ if the plan contains varying limits on different medical/surgical benefits, the plan may apply an average limit to mental health benefits. • Requires annual visit limits equal to or greater than 20 hospital inpatient days and 25 outpatient or doctor visits (prohibits counting a visit for medication management as an outpatient visit). • Allows substitution of less costly residential treatment, partial hospitalization, or crisis respite care at the rate of 2 alternate care days to 1 day of inpatient hospital treatment. • Prohibits an affected entity from counting an outpatient medication management visit as an outpatient visit for purposes of determining compliance with the annual visit limit (noted above). • Allows a separate limit for mental health services for out-of-pocket cost sharing that is higher than a limit applied to medical/surgical benefits. • Prohibits the denial of coverage for services provided while confined in a hospital owned or operated by this state that is especially intended for use in the diagnosis, care and treatment of psychiatric, mental or nervous disorders. **Benefit management:** Allows the use of managed care practices for the delivery of benefits. **Exemption for cost increases:** Gives the commissioner the authority to grant an exemption if an affected entity submits documentation that the application of the mandate results in an increase in cost of more than 1%. **Rule of construction:** Provides that the provisions should not be construed to limit the amounts and terms of coinsurance, co-pays, deductibles, or differentials required to be paid by the enrollee. • Clarifies that the mandate to provide coverage for mental health services at the same rates and terms as coverage provided for all medical/surgical conditions

State law	Applicability	Definitions	Major provisions
			does not apply to services for the abuse of or dependency on alcohol or drugs.
Tennessee *Tenn. Code Ann. §56-7-2601* Effective 1974 Amended 2000	Individual, franchise, blanket or group policies, group hospital or major medical policies, nonprofit hospital and medical service plan corporations.	*"Mental or nervous conditions"* means conditions as defined in the DSM. The term does not include benefits for the treatment of substance abuse or chemical dependency. "*Annual limit*" means a dollar limitation on the total amount that may be paid for benefits in a 12-month period under a health plan with respect to an individual or other coverage unit.	**Mental health coverage requirements:** Except for group policies or plans to which §56-7-2360 applies (see above), requires affected entities which provide hospital expense and surgical expense insurance to either: ▪ provide benefits for expenses arising from psychiatric disorders, mental or nervous conditions, or the medical complication of mental illness or mental retardation; or ▪ specifically exclude or reduce the above benefits. • Requires affected entities which propose to issue group hospital, major medical, or medical policies or contracts to make available coverage for outpatient expenses at a community mental health center for the treatment of mental, emotional or nervous disorders, alcoholism, drug dependence, and the medical complication of mental illness or mental retardation, unless the policy or contract is rejected in writing by the policy or contract subscriber. • Subject to §56-7-2360 (see above), allows a group health plan providing both medical and surgical benefits and mental health benefits to impose aggregate lifetime limits or annual limits as follows: ▪ if the plan places no limit on substantially all medical and surgical benefit, the plan may place no limit on mental health benefits; ▪ if a group health plan places limit on substantially all medical and surgical benefits, the plan may include mental health benefits under the limit or to apply a separate limit no less than the one applied to medical and surgical benefits; or ▪ if the plan contains varying limits on different medical or surgical benefits, the plan may apply an average limit to mental health benefits. • Clarifies that the above provisions on aggregate and annual limits do not require a group health plan to provide mental health benefits. • Exempts from the provisions on aggregate and annual limits: ▪ group health plans issued to small employers of 2-25 employees; and ▪ group health plans with an increase of cost of at least 1% because of application of the provision. **Scope of coverage:** Requires the coverage to be made available for services rendered at a community mental health center to include: • the same deductibles and coinsurance as physical illnesses; and • a minimum of 30 outpatient visits annually.

State law	Applicability	Definitions	Major provisions
Tennessee *Tenn. Code Ann. §56-7-2602* Effective 1982	Group health insurers, non-profit hospitals and medical service plan corporations, and HMOs. Does not apply to blanket, short term travel, accident only, limited or specified disease, individual conversion policies, or federal or state programs.	No definitions.	**Substance abuse mandated offer requirements:** Requires affected entities providing hospital and medical coverage to offer and make available benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illnesses generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors. • Allows group policyholders to reject the offered coverage.
Tennessee *Tenn. Code Ann. §56-6-705* Effective 2007	Utilization review agents.	No definitions.	**Mental health and substance abuse coverage requirements:** Requires affected entities to approve at least 12 visits to a particular provider for outpatient mental health and chemical dependency care for a patient once the patient has registered pursuant to policy or contract requirements. • Requires affected entities to provide 12 additional visits or as otherwise recommended after a utilization review.
Texas *Tex Code Ann. Ins. §1355.001, et. seq.* Effective 1991 Amended 2003 *Tex Code Ann. Ins. §1355.051, et. seq.* Effective 1987 Amended 2003 *Tex Code Ann. Ins. §§1355.104*	Group health benefit plans. Does not apply to blanket accident policies, short-term travel policies, accident-only policies, limited or specified-disease policies, and Medicare supplement policies.	*"Serious mental illness"* means the following psychiatric illnesses as defined by the DSM: • schizophrenia; • paranoia and other psychotic disorders; • bipolar disorders; • major depressive disorders (single episode or recurrent); • schizoaffective disorders (bipolar or depressive); • pervasive developmental disorders; • obsessive compulsive disorders; and	**Mental health coverage requirements:** Requires affected entities, except small employers (defined as employers with 50 employees or less) to *provide* the coverage outlined below. • Requires affected entities to *offer* the coverage outlined below to small employers. • Requires affected entities to *offer* coverage for "alternate benefits" (undefined) for treatment of mental or emotional illnesses or disorder when confined in a hospital or a psychiatric day treatment facility. **Scope of coverage:** Requires coverage of medically necessary treatment of 45 days inpatient and 60 visits for outpatient, including group and individual outpatient treatment. • Prohibits the inclusion of lifetime limits on the number of days of inpatient or outpatient visits covered. • Requires the imposition of the same amount limits, deductibles, co-pays and

State law	Applicability	Definitions	Major provisions
through1355.106 Effective 1983 Amended 2003		• depression in childhood and adolescence. Hospital confinement provisions stipulate that coverage may be used only in a situation in which the individual has a serious mental illness that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and the individual's mental illness: • substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or • as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.	coinsurance factors for serious mental illness as for physical illness. • Requires affected entities providing coverage for the treatment of mental or emotional illnesses or disorders when the individual is confined in a hospital to also provide coverage for treatment in a residential treatment center for children and adolescents or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of mental or emotional illness or disorder in a hospital. ▪ Requires hospital confinement coverage to be based on an individual treatment plan for the covered individual and provided by a service provider licensed or operated by the appropriate state agency to provide those services. ▪ Requires hospital confinement benefits to be subject to the same benefit maximums, durational limitations, deductibles, and co-insurance factors that apply to inpatient psychiatric treatment. ▪ Requires treatment in a residential treatment center for children and adolescents or crisis stabilization unit to be determined as if necessary care and treatment were inpatient care and treatment in a hospital. ▪ Requires 2 days of treatment in a residential treatment center for children and adolescents or crisis stabilization unit to be equivalent to 1 day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. • Requires group insurance policies providing coverage for the treatment of mental or emotional illness or disorder when an individual is confined in a hospital to also provide coverage for treatment obtained under the direction and continued medical supervision of a doctor in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an inpatient program. ▪ Requires benefits provided to be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient treatment in a hospital. ▪ Requires, with respect to determining policy benefits and benefit maximums, that one full day of treatment in a psychiatric day treatment facility to be equivalent to ½ of 1 day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. ▪ Prohibits psychiatric day treatment facility coverage from being less favorable than the hospital coverage, and requires them to be subject to the same durational limits, deductibles, and coinsurance factors as hospital coverage. ▪ Permits treatment obtained in a psychiatric day treatment facility to be

State law	Applicability	Definitions	Major provisions
			provided by a facility that treats a patient for not more than 8 hours in any 24 hour period. ▪ Permits the requirement that attending physicians certify that treatment in a psychiatric day treatment facility is in lieu of hospitalization. ▪ Permits the requirement that psychiatric day treatment facilities to be accredited by the Joint Commission on Accreditation of Hospitals. • Requires alternative level of benefits to provide policy benefits and benefit maximums for treatment in a psychiatric day treatment facility equal to or at least half of that provided for treatment in a hospital, except that benefits for treatment in a psychiatric day treatment facility may not exceed then usual and customary rate of the facility. **Benefit management:** Permits coverage to be provided or offered through a managed care plan.
Texas *Tex. Code Ann. Ins §1551.205* Effective 2001 *Tex. Code Ann. Ins. §1355.151* Effective 2003	State government employees and political subdivisions of local governments providing group health insurance, HMO, or self-insured health coverage.	*"Serious mental illness"* means the following psychiatric illnesses as defined in the DSM: • bipolar disorders (hypomanic, manic, depressive, and mixed); • depression in childhood and adolescence; • major depressive disorders (single episode or recurrent); • obsessive-compulsive disorders; • paranoid and other psychotic disorders; • pervasive developmental disorders; • schizo-affective disorders (bipolar or depressive); and • schizophrenia.	**Mental health parity requirements:** Prohibits the state and political subdivisions of local governments from providing or contracting for coverage for serious mental illness that is less extensive than coverage for any physical illness.
Utah *Utah Code Ann.*	Group accident and health insurance.	No definitions.	**Substance abuse mandated offer requirement:** Requires affected policies to contain an optional rider allowing certificate holders to obtain coverage for alcohol or

State law	Applicability	Definitions	Major provisions
§31A-22-715 Effective 1986 Amended 2001			drug dependency treatment in programs licensed by the Department of Human Services, inpatient hospitals accredited by the Joint Commission on the Accreditation of Hospitals, or facilities licensed by the Department of Health.
Utah *Utah Code Ann. §31A-22-625* Effective 2000 Amended 2008	Insurers.	"*Catastrophic mental health coverage*" means coverage in a health benefit plan or HMO contract that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition. • The term may include a restriction on cost sharing factors, such as deductibles, copays, or coinsurance, prior to reaching any maximum out-of-pocket limit. • It may include 1 maximum out-of- pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, provided that, if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.	**Mental health coverage requirements:** Requires an insurer to offer catastrophic mental health coverage as part of an HMO contract or health benefit plan. • Does not apply to individual policies or contracts. **Mental health mandated offer requirements for small employers:** Requires an insurer to offer small employers (defined as 2 – 50 employees), at the time of purchase and renewal, a choice between catastrophic mental health coverage and 50/50 mental health coverage. • Allows an insurer to offer catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or coverage that excludes benefits for mental health conditions. • Permits a small employer, at its option, to choose either catastrophic mental health coverage, 50/50 mental health coverage, or other coverage offered by the insurer, regardless of the employer's previous coverage for mental health conditions. • Provides an exemption from the 30% index rating restriction imposed under state law for the first year only that catastrophic mental health coverage is chosen, the 15% annual adjustment restriction under state law, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage. **Mental health mandated offer requirements for large employers:** Requires insurers, at the time of purchase and renewal, to offer catastrophic mental health coverage to each large employer (defined as 51 or more employees). • Allows an insurer to offer to provide catastrophic mental health coverage at levels that exceed the minimum requirements of this law. • Permits a large employer, at its option, to choose either catastrophic mental health coverage, coverage that excludes benefits for mental health conditions, or other coverage offered by the insurer. **Benefit management:** Allows an insurer to provide catastrophic mental health coverage through a managed care organization or system in a manner consistent with state law, regardless of whether the policy or contract uses a managed care or-

State law	Applicability	Definitions	Major provisions
		"50/50 mental health coverage" means coverage in a health benefit plan or HMO contract that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions. • The phrase may include a restriction on episodic limits, inpatient or outpatient service limits, or maximum out-of-pocket limits. "*Mental health condition*" means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual, as periodically revised. • It does not include the following when diagnosed as the primary or substantial reason or need for treatment: (a) marital or family problem; (b) social, occupational, religious, or other social maladjustment; (c) conduct disorder; (d) chronic adjustment disorder; (e) psychosexual disorder; (f) chronic organic brain syndrome; (g) personality disorder; (h) specific developmental disorder or learning disability; or (i) mental retardation.	ganization or system for the treatment of physical health conditions. • Permits insurers to establish a closed panel of providers for catastrophic mental health coverage. • Allows insurers to refuse to provide any benefit to be paid for services rendered by a non-panel provider unless: ▪ the insured is referred to a non-panel provider with the prior authorization of the insurer; and ▪ the non-panel provider agrees to follow the insurer's protocols and treatment guidelines. • Provides that to be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition must be rendered by a mental health therapist or in a health care facility licensed or otherwise authorized to provide mental health services that provides a program for the treatment of a mental health condition pursuant to a written plan. **Out-of-network services:** Provides that nothing may be construed as requiring an insurer to authorize a referral to a non-panel provider.
Vermont	Insurers and managed	*"Mental health condition"* means	**Mental health and substance abuse parity requirements:** Requires affected enti-

State law	Applicability	Definitions	Major provisions
Vt. Stat. Ann. §§4089b and 9414(g) Effective 1998 Amended 2008	care organizations offering health insurance plans including those offered by the state. Requires a managed care organization providing or administering coverage on behalf of insurance plans to abide by the same rules as the insurer. Assigns a health insurer responsibility for the actions of a managed care organization it contracts with.	any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the ICD classification.	ties to provide coverage for treatment of a mental health condition and to not establish any rate, term or condition that places a greater burden on an insured for access to treatment for a mental health condition than for access to treatment for other health conditions. **Scope of coverage:** Requires any deductible or out-of-pocket limits to be comprehensive for coverage of both mental health and physical health conditions. **Benefit management:** Allows affected entities to provide services through an approved managed care organization to the extent that the affected entity does not otherwise provide for management of care under the plan or the same degree of management for all health conditions.
Vermont *Vt. Code R. §80-1* Effective 1980	All individual accident and sickness insurance policies and subscriber contracts of hospital, medical and dental service corporations except Medicare supplement policies or certificates, delivered or issued for delivery. Does not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individu-	*"Mental or nervous disorders"* includes neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.	**Mental health parity requirements:** Prohibits an affected insurance policy or contract from containing a definition for "mental or nervous disorders" that is more restrictive a definition than one including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. • Prohibits policies from limiting or excluding coverage by type of illness, accident, treatment or medical condition except, among other things, mental or emotional disorders, alcoholism, and drug addiction.

State law	Applicability	Definitions	Major provisions
	al policy or contract includes provisions which are inconsistent with the requirements of this regulation.		
Virginia *Va. Code Ann. §38.2-3412.1* Effective 2004	Insurers offering individual and group accident and sickness policies. Does not apply to short-term travel, accident-only or specified disease policies, short-term nonrenewable policies, Medicare or federal or state government plans.	No definitions.	**Mental health and substance abuse coverage requirements:** Requires affected entities to provide coverage for inpatient and partial hospitalization mental health and substance abuse services that are no less restrictive than for any other illness (except as outlined below). **Scope of coverage:** Requires coverage for: • 20 days of inpatient treatment for adults and 25 days of inpatient treatment for children per policy or contract year; • up to 10 days of inpatient care which can be converted for children to 1½ days of partial/residential treatment for 1 day of inpatient treatment; • 20 days of outpatient treatment for adults and children per policy or contract year; • coinsurance for outpatient visits beyond the first 5 visits covered in any policy or contact year shall be at least 50% percent; and • outpatient visits subject to a deductible (does not count toward outpatient visit benefit maximum).
Virginia *Va. Code Ann. §38.2-3412.1:01* Effective 2000 Amended 2004	Insurers, corporations, and HMOs issuing or providing group policies. Does not apply to short-term travel, accident-only or specified disease policies, short-term nonrenewable policies, Medicare or federal or state government plans.	*"Biologically based mental illness"* means any mental or nervous condition caused by a biological disorder of the brain that result in a clinically significant syndrome that substantially limits the person's functioning. The definition includes: • schizophrenia; • schizo-affective disorder; • bipolar disorder; • obsessive-compulsive disorder; • major depressive disorder;	**Mental health and substance abuse coverage requirements:** Requires affected entities to provide coverage for biologically based mental illness. **Scope of coverage:** Permits benefits for biologically based mental illness to be different from benefits for other illnesses, conditions, or disorders if such benefits meet the medical criteria necessary to achieve the same outcomes as are achieved by the benefits for any other covered illness, condition or disorder. • Prohibits terms of mental health coverage from being different or separate from coverage for any other illness, condition or disorder in determining: ▪ deductibles, benefit year, or lifetime durational limits; ▪ benefit year or lifetime dollar limits; ▪ lifetime episodes or treatment limits; ▪ co-pay or coinsurance factors; and ▪ benefit year maximums for deductibles, co-pay and coinsurance factors.

State law	Applicability	Definitions	Major provisions
	Does not apply to individual policies or policies issued to employers with 25 or fewer employees.	• panic disorder; • attention deficit disorder; • autism; and • drug and alcohol addiction.	**Benefit management:** Does not preclude insurers from rendering medical necessity determinations on mental health benefits as long as the criteria for the determinations are the same as those used for other illnesses, conditions or disorder covered under the contract.
Washington *Wash. Rev. Code §§48.21.180 and 48.44.240* Effective 1990	Group disability insurers[4] and group contracts for health care services.	No definitions.	**Substance abuse coverage requirements:** Requires affected entities to provide benefits for the treatment of chemical dependency rendered by an approved treatment facility or program. **Scope of coverage:** Requires coverage to provide payment for reasonable charges for any medically necessary treatment and supporting services provided by an approved treatment program with a minimum benefit of $10,000 within a 24-month period. • Allows coverage to be limited by provisions of the policy that are applicable to other benefits. • Allows a 3 month pre-existing limitation if the limitation also applies to other chronic illnesses. **Benefit management:** Permits limiting coverage to specific facilities, but only if the carrier provides or contracts for the provision of approved treatment programs. • Except for detoxification services, allows a requirement for pre-notification and second opinions, if the second opinion is required for other chronic illnesses. • Permits a carrier to make an independent evaluation of medical necessity prior to scheduled treatment in situations where the assessment of treatment is under court order or related to certain legal proceedings.
Washington *Wash. Rev. Code §48.21.240* Effective 1987 Amended 2005	Group disability insurers, including insurers, health care service contractors, and HMOs.	No definitions.	**Mental health mandated offer requirements:** Requires affected entities to offer optional supplemental coverage for mental health treatment. **Scope of coverage:** Permits treatment to be subject to "reasonable" deductible amounts or co-pays. • Requires coverage to be provided by a state licensed physician, psychologist,

[4] In Washington, health insurance is known as "disability insurance." For more information, see AHIP's *Disability Income Protection and Health Insurance: State Definitions* chart.

State law	Applicability	Definitions	Major provisions
			community mental health agency, or state hospital. • Requires coverage to be provided at the usual and customary rates for such treatment; however, allows affected entities to establish separate usual and customary rates for services rendered by the above-stated providers.
Washington *Wash. Rev. Code §§41.05; 48.21; 48.44; 48.46; and 70.47* Effective 2005 Amended 2006	Public employees program; Washington Basic Health Plan; and group disability insurers, health care service contractors, and HMOs providing medical and surgical benefits to groups with 50 or more employees.	*"Mental health services"* means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the DSM, with the exception of: • substance related disorders; • life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the DSM; • skilled nursing facility services, home health care, residential treatment, and custodial care; and • court ordered treatment unless the authority's or contracted insuring entity's medical director determines the treatment to be medically necessary.	**Mental health coverage requirements:** Requires affected entities to provide coverage for mental health services. **Scope of coverage:** Prohibits co-pays or coinsurance for mental health services from being more than the co-pays or coinsurance for medical/surgical services, except for wellness and preventive services provided or reimbursed at a lesser co-pay, coinsurance, or other cost sharing than other medical/surgical services. • Requires prescription drugs intended to treat any of the covered disorders to be covered to the same extent, and under the same terms and conditions, as other covered prescription drugs. • For health benefit plans established or renewed on or after January 1, 2008, also requires that any maximum out-of-pocket limit or stop loss to be a single limit or stop-loss for medical, surgical, and mental health services. • For health benefit plans established or renewed on or after July 1, 2010, also requires mental health services to be included with medical and surgical services for the purpose of meeting the deductible requirement. In addition, only permits treatment limitations on or any other financial requirements for coverage for mental health services if the same limitations or requirements are imposed on coverage for medical and surgical services. • Prohibits affected entities from reducing the number of mental health outpatient visits or inpatient days below the level in effect on 07/01/02. **Benefit management:** Permits the application of medical necessity, as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services. • Permits the management of mental health services. • Requires the administrator to consider care management techniques for mental health services, including but not limited to: ▪ authorized treatment plans; ▪ preauthorization requirements based on the type of service; ▪ concurrent and retrospective utilization review; ▪ utilization management practices;

State law	Applicability	Definitions	Major provisions
			▪ discharge coordination and planning; and ▪ contracting with and using a network of participating providers.
Washington *Was. Rev. Code §§48.20.580; 48.21.241; 48.44.341; and 48.46.291* Effective 2008	Group insurance (except for small groups) provided by disability insurers; health service contracts providing health benefit plans; and HMOs; and the state's high risk pool	"*Mental health services*" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the DSM with the exception of the following categories, codes, and services: a) substance related disorders; b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9; c) skilled nursing facility services, home health care, residential treatment, and custodial care; and d) court-ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary.	**Mental health parity requirements:** Prohibits co-pays and coinsurance for mental health services from being more than those for medical and surgical services otherwise provided under the contract. • Requires contracts imposing a maximum out-of-pocket limit or stop loss, to impose a single limit or stop-loss for medical, surgical, and mental health services. • Requires prescription drugs for mental illnesses to be covered to the same extent and under the same terms and conditions as other covered prescription drugs. **Scope of coverage:** Requires contracts imposing a maximum out-of-pocket limit or stop loss, to impose a single limit or stop-loss for medical, surgical, and mental health services. • Requires prescription drugs for mental illnesses to be covered to the same extent and under the same terms and conditions as other covered prescription drugs. • Prohibits the reduction of the number of mental health outpatient visits or inpatient days below the level in effect on 07/01/02. • Requires the policy issued by the state's high-risk pool to cover medically necessary eligible services including mental health care services, • Requires the state's high-risk pool to cover the first 20 outpatient visits rendered at a state-certified chemical dependency program or by 1 or more physicians, psychologists, or community mental health professionals or at the direction of a physician, by other qualified licensed health care practitioner is eligible for coverage. **Benefit management:** Allows for the application of medical necessity criteria by the medical director or designee, if a comparable requirement is applicable to medical/surgical services.
West Virginia *W. Va. Code §33-16-3c*	Group, blanket, franchise or association accident and sickness insurance.	*"Alcoholism"* means a chronic disorder or illness in which the individual is unable, for psychological or physical reasons, or	**Substance abuse mandated offer requirements:** Requires affected entities to, at the option of the policyholder or sponsor, provide the level of benefits specified for alcoholism.

State law	Applicability	Definitions	Major provisions
Effective 1998		both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and ultimately, injury to health and effective functioning.	**Scope of coverage:** Requires: • a minimum of 30 days of inpatient treatment (if inpatient hospital benefits are provided beyond 20 days, the durational limits, dollar limits, deductibles and coinsurance need not be the same as for physical illnesses); • maximum coinsurance for outpatient benefits of 50% of the coinsurance for physical illnesses; • minimum benefit in any benefit period of at least $750; and • maximum lifetime benefits of at least $10,000 or 25% of the lifetime limit.
West Virginia *W. Va. Code §33-16-3a* Effective 1998 Amended 2007	Health benefit plans, insurers, and HMOs offering group and individual coverage.	*"Serious mental illness"* means an illness included in the DSM under the diagnostic categories or sub-classifications of: • schizophrenia and other psychotic disorders; • bipolar disorders; • depressive disorders; • substance-related disorders with the exception of caffeine and nicotine--related disorders; • anxiety disorders; and • anorexia and bulimia. Does not include custodial care, residential care, or schooling.	**Mental health coverage requirements:** Requires affected entities to provide benefits for expenses arising from treatment of serious mental illness. • Prohibits discrimination between medical-surgical benefits and mental health benefits in the administration of its plan. **Scope of coverage:** Requires aggregate lifetime and annual limits to be applied as follows: ▪ prohibits a plan from imposing any aggregate lifetime or annual limits on mental health benefits if the plan does not include an aggregate lifetime or annual limit on substantially all medical/surgical benefits, as defined under the terms of the plan, but not including mental health; ▪ requires a plan that limits the total amount that may be paid with respect to coverage for substantially all medical/surgical benefits, to either apply the applicable lifetime or annual limit to medical/surgical benefits to which it would otherwise apply and to mental health benefits (as defined under the terms of the plan) without distinguishing between such benefits, or including any aggregate lifetime or annual limit on mental health benefits that is less than the applicable lifetime limit; • Permits the commissioner to impose rules for those plans not previously described above with respect to prohibiting different aggregate lifetime or annual limits on different categories of medical/surgical benefits. **Benefit management:** Permits insurers to use recognized health care quality and cost management tools, including, but not limited to: ▪ utilization review; ▪ provider networks; ▪ cost containment measures; ▪ preauthorization; ▪ coverage levels including the number of visits in a given time period;

State law	Applicability	Definitions	Major provisions
			▪ capitated benefit arrangements; ▪ fee-for-service arrangements; ▪ third-party administrators; ▪ cost-sharing in the form of co-pays, deductibles, and coinsurance. **Exemption for cost increases:** Permits insurers that can actuarially demonstrate that its total anticipated costs for treatment for mental illness for any benefit plan will exceed or have exceeded 2% of the total costs for such plan in any experience period to apply whatever cost containment measures may be necessary, including, but not limited to, limitations on inpatient and outpatient benefits, to maintain costs at below two percent of total costs. • Allows insurers to apply additional cost containment measures as may be necessary for any group with 25 members or fewer if the total anticipated actual costs for the treatment of mental illness will exceed 1% of the total costs for the group.

State law	Applicability	Definitions	Major provisions
Wisconsin *Wis. Stat. §632.89* Effective 2000 Amended 2006	Group or blanket disability insurers.[5] Does not apply to limited health service organizations.	No definitions. Does not include costs incurred for prescription drugs and diagnostic testing.	**Mental health coverage requirements:** Requires affected entities providing coverage of any inpatient hospital services to cover inpatient services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems as provided below. **Scope of coverage:** Mandates coverage in an amount equal to the lesser of: ▪ the expenses of 30 days of inpatient services; or ▪ $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. • Requires affected entities providing coverage of any outpatient hospital services to cover outpatient services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of: ▪ $2,000 minus the applicable cost sharing under the policy, or ▪ if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. • Requires affected entities providing coverage of any inpatient or outpatient hospital services to cover the cost of transitional treatment arrangements for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of: ▪ $3,000 minus the applicable cost sharing under the policy or, ▪ if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. • Provides that the required coverage amounts do not include costs for prescription drugs and for diagnostic testing used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse. • Provides that coverage for both inpatient and outpatient hospital services for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems need not exceed $7,000/policy year, or the equivalent benefits measured in services rendered in a policy year. • Requires affected entities paying less than the amount that a provider charges to have minimum coverage limits apply to the amount actually paid by the insurer rather than to the amount charged by the provider.

[5] In Wisconsin, health insurance is known as "disability insurance." For more information, see AHIP's *Disability Income Protection and Health Insurance: State Definitions* chart.