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Understanding the Massachusetts and Federal Mental Health Parity Laws

Introduction

Coverage of mental health and substance use disorder services has received a tremendous amount of attention over recent years. With issues such as long wait times in hospital emergency departments and the rise of opioid-related overdoses, stakeholders and policy-makers have been looking to implement measures to help individuals obtain the services that they need. Health plans play an important role in ensuring access to behavioral health services and are subject to stringent state and federal laws requiring parity in coverage between behavioral health and substance use disorder conditions and other medical conditions. What "parity" requires and what it does not address are often misconstrued. Hospitals and other medical providers, for example, are not subject to the parity laws, yet a lack of parity is often cited as the cause for the perceived disparate treatment of patients, particularly those experiencing long wait times in emergency rooms. A multi-stakeholder working group convened by the Massachusetts Executive Office of Health and Human Services is currently exploring measures to reduce emergency room wait times for patients with behavioral health needs. The working group will make targeted short and long term recommendations relating to data collection, licensure and delivery system changes, outpatient and community-based services, and rates and payment methodologies. Massachusetts reports a high number of visits for behavioral health services[1] and is reported to have the highest percentage of licensed mental health professionals in the country,[2] yet individuals still report tremendous challenges obtaining necessary care. This OnPoint is intended to provide a clear description of both the state and federal mental health parity laws and regulations, including applicability, oversight, and enforcement in order to help readers understand the scope of the laws, identify open questions, and address common misconceptions.

Summary of Current State Mental Health Parity Law

The original Massachusetts mental health parity law (MMHPL), was drafted in collaborative fashion during the 1999–2000 legislative session and has been updated over the years.[3]

Applicability of the State Mental Health Parity Law

The scope of the MMHPL and all state laws and regulations governing patient protections are limited to only those health plans subject to state law. These include:

- Fully insured small group health plans, typically small or midsize businesses
- Health plans in the individual market, including those purchased through the Connector
- Health coverage offered through the Group Insurance Commission (GIC)

Large companies typically "self-insure," providing employee health benefits by directly paying health care claims to providers, and are governed by the federal Employee Retirement Income Security Act (ERISA). States are preempted from regulating self-insured plans under ERISA. Approximately 60 percent of the 4.5 million individuals enrolled in commercial coverage in Massachusetts are covered by a self-insured plan, and employers that self-insure are not subject to state-mandated benefits.[4]

What the Law Requires

The law requires health plans to cover on a nondiscriminatory basis "biologically based mental disorders" that are described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. The initial list of biologically based disorders required for coverage included: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; and affective disorders. The requirement to cover these disorders on a nondiscriminatory basis meant that a health plan had to cover services

for those disorders in the same way it covered services for medical treatments. A health plan could not impose more stringent limits on the listed behavioral health services than it did for coverage for medical treatments. Annual or lifetime dollar or unit-of-service limitations were also prohibited. Finally, the state Mental Health Parity Law included a separate provision applying solely to children and adolescents under the age of 19, for whom carriers were directed to cover, on a nondiscriminatory basis, non-biologically based mental, behavioral or emotional disorders described in the DSM that substantially interfere with or substantially limit their functioning and social interactions.

Health plans were required to cover services for all other mental health disorders; however, that coverage could be subject to limits described in the law. Coverage for these so-called non-biologically based disorders could be limited to 60 days of inpatient treatment and for a minimum of 24 outpatient visits in a 12-month time period. As discussed below, this distinction between biologically based and non-biologically based diagnoses continued until the implementation of the federal mental health parity law in 2010.

The Massachusetts Mental Health Parity Law further required coverage of a range of inpatient, intermediate, and outpatient "medically necessary and active non-custodial treatment for said mental disorders to take place in the least restrictive setting."[5] Outpatient services were included as part of the coverage mandate, provided that the services are rendered by a licensed mental health professional acting within the scope of their license. The original law provided a list of who was considered to be a licensed mental health professional.[6] This definition has been expanded to include licensed marriage and family therapists and licensed alcohol and drug counselors.[7]

Over the last several legislative sessions, there has been a significant expansion of the Mental Health Parity Law. In 2008, the Parity Law was expanded by Chapter 256 of the Acts of 2008 to include eating disorders, post-traumatic stress disorders, substance use disorders and autism among the list of biologically based disorders. That same year, new reporting and patient safety requirements were added for behavioral health coverage.[8] Under the new requirements, health plan members could request the right to ask for help from a carrier in obtaining medically necessary services if they or their primary care provider are unable to find the appropriate providers within the network. In the event the health plan is not able to find an available provider within the network, the health plan is required to find an appropriate out-of-network provider. These new requirements codified existing health plan practice but were aimed at addressing concerns relating to the ability to access behavioral health providers within health plan networks.

In 2010, the requirement that health plans provide coverage for the diagnosis and treatment of autism spectrum disorders was expanded with the passage of Chapter 207 of the Acts of 2010. Chapter 207 required nondiscriminatory coverage of services for autism spectrum disorders, including applied behavior analysis, and prohibited any annual or lifetime dollar or unit-of-service limitations. Chapter 207 retained the distinction between services that are covered by health plans and those that are educational in nature and provided by the schools.[9]

Additional Consumer Protection Laws

In addition to the state's Mental Health Parity Law, health plans are subject to comprehensive state laws and regulations governing health plan utilization management activities. In 2000, the Legislature passed a comprehensive Patient's Bill of Rights, Chapter 141, which established an independent appeal process to resolve coverage disputes in a timely, inexpensive, and impartial manner. Current state law contains requirements related to adverse determinations, carrier internal and external appeals requirements, and consumer notification and accreditation requirements.[10] Section 13 of Chapter 176O requires licensed health plans to maintain a formal internal grievance process that provides for adequate consideration and timely resolution of grievances. Section 13 further requires health plans to maintain a process for expedited internal reviews, as necessary for immediate and urgently needed services. Section 14 of Chapter 176O provides for an external review process for consumers following the health plans' internal review. The Office of Patient Protection (OPP), which is part of the Health Policy Commission, administers an independent external review process for final coverage decisions based on medical necessity. OPP has promulgated regulations governing both the health plans' internal grievances programs and the external review process administered by OPP. OPP's regulations contain robust oversight of internal and external appeals processes.

Finally, both state and federal law require health plans to provide access to the criteria used to conduct all utilization review activities.[11] Massachusetts state law requires health plans to make such criteria accessible on their websites and available upon request to the general public if the criteria are developed by the health plan and not otherwise proprietary. There is no requirement to post proprietary data on the health plan's website. However, health plans must provide access to criteria that are relevant to particular treatments and services to their members, prospective members, and health care providers upon request. The federal rules require that health plans make available the criteria used for medical necessity determinations with respect to mental health and substance use disorder benefits to any current or potential participant, beneficiary, or contracting provider upon request.[12]

Summary of the Federal Mental Health Parity Law

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008,[13] and amended the Mental Health Parity Act of 1996. MHPAEA, in general, requires that certain group health plans apply the same treatment limits and financial requirements to mental health and substance use disorder benefits as they do for medical and surgical benefits. Interim Final Regulations were issued February 2, 2010,[14] and Final Regulations were issued November 13, 2013.[15] The regulatory

authority to implement MHPAEA resides with both the United States Department of Labor and the Department of Health and Human Services. Pursuant to the Final Rule, states have primary enforcement authority regarding the federal mental health parity regulations.[16]

MHPAEA itself does not mandate coverage of mental health and substance use disorder benefits. Instead, it requires that if treatment for these conditions is included as a benefit, health plans have to provide it under the same terms and conditions as they would for other covered medical treatment. However, as discussed below, following enactment of the Affordable Care Act (ACA), all health plans in the individual and small-employer market, both inside and outside the Exchanges, must include coverage for the treatment of mental health and substance use disorders.

Applicability of MHPAEA

MHPAEA applies to several types of health plans; however, not all health plans are subject to the law. Those included are:

- Large employer-sponsored health plans with 51 insured employees or more, both self-funded and fully insured;
- Small employer-sponsored health plans purchased through an Exchange;
- Health plans in the individual market;
- Medicaid managed care organizations (MCOs);
- Medicaid Children's Health Insurance Program (CHIP) plans;
- Medicaid alternative benefit plans and benchmark plans; and
- All employees covered through the Federal Employees Health Benefit Programs, to which the federal Office of Personnel Management has also applied MHPAEA requirements despite the program not being included in the law.[17]
- Fully insured small group health plans were not initially subject to the law; however, through the ACA they must comply with the requirements of MHPAEA (see below);

Exempted from MHPAEA:

- Church-sponsored health plans;
- Self-insured health plans sponsored by state and local governments;
- Retiree-only health plans;
- Tricare;
- Medicare; and
- Traditional Medicaid fee-for-service, or non-managed, care[18]

Initially, health plans offered in the individual market were not subject to the requirements of the federal law. The MHPAEA does not directly apply to fully insured small group health plans. However, through implementation of the Affordable Care Act (ACA), the Federal Department of Health and Human Services issued a regulation governing Essential Health Benefits that required individual and small group health plans to provide coverage of all Essential Health Benefits, including mental health and substance use disorder benefits, and further required that health plans offer those benefits in compliance with MHPAEA.[19] The ACA, in effect, went beyond the Parity Law to mandate coverage of mental health and substance use disorder services. Qualifying plans must therefore comply with the benefit mandates of ACA and MHPAEA.

The MHPAEA contained a cost exemption for health plans that have experienced an increase in cost following implementation of the requirements, which applied to health plans that incurred an increase of at least 2 percent in the first year that MHPAEA applied to the plan, or at least 1 percent in any subsequent plan or policy year.[20] If the plan's costs exceed the baseline requirements, the plan is exempted for the next plan year. However, the exemption only lasts for one year and the plan must comply with the law for the following year. It is therefore possible that a plan may comply with the requirements every other year.

In Massachusetts, this means that large employers, both fully insured and self-insured, and small group fully insured health plans are subject to the federal law. Additionally, all health plans offered through the state's Exchange and Medicaid MCOs that provide coverage through the state's Medicaid program, MassHealth, must all comply with the federal law.

What the Law Requires

While MHPAEA does not mandate coverage of specific benefits, health plans that offer mental health and substance use disorder benefits and services must comply with MHPAEA in how such benefits are designed and implemented. Mental health and substance use disorder benefits must not be offered in a way that is more restrictive than benefits for medical or surgical conditions. The law and regulations outline a framework for how health plans can determine whether their benefits are equivalent. Health plans subject to MHPAEA must comply with three mandates: (1) a prohibition on annual or lifetime limits, (2) a requirement for parity in the quantitative limitations, and (3) parity in nonquantitative limitations. Quantitative and nonquantitative limitations will be discussed in further detail below.

The federal rules outline six benefit classifications in which mental health and substance use disorder benefits are compared to medical/surgical benefits. MHPAEA requires that services be equivalent within each of the below treatment classifications:

1. In-network inpatient;
2. Out-of-network inpatient;
3. In-network outpatient;
4. Out-of-network outpatient; [21]
5. Emergency care; and
6. Prescription drugs.[22]

EXAMPLE

If a plan does not offer any out-of-network outpatient medical surgical benefits, then there is no requirement to offer out-of-network outpatient mental health or substance use disorder services.[23]

The federal rules state that how a health plan defines mental health and substance use disorder services is subject to terms of the plan and in accordance with applicable federal and state law. As discussed above, the requirements for what Massachusetts health plans that are subject to state law must cover are governed by the state's Mental Health Parity Law. In addition, the definitions for the terms inpatient, outpatient, and emergency care are also subject to plan design or potentially defined through state law.[24]

With regard to intermediate alternate levels of care of mental health and substance use disorder services (i.e., residential services, intensive outpatient, and partial hospitalization), plans and issuers must assign covered intermediate mental health and substance abuse benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.[25]

Financial Requirements – Quantitative Treatment Limits

MHPAEA and the Final Rules prohibit health plans from imposing more restrictive financial requirements, or quantitative treatment limits, on mental health and substance use disorder benefits than the "predominant" financial requirements applicable to "substantially all" medical/surgical benefits in the same classification.[26]

The first step is to determine whether a quantitative treatment limit, such as a copayment, applies to "substantially all" of the medical/surgical benefits in a classification. If the quantitative treatment limit does not apply to at least two-thirds of the medical/surgical benefits in the classification, such as outpatient services, then it cannot be applied to mental health and substance use disorder services in that classification. If a single level of a type of quantitative limit, such as a copayment, applies to at least two-thirds of the medical/surgical benefits in a classification, then it is also considered to be predominant. If not, and the limit applies to two-thirds of the benefits but at multiple levels, then an additional step of analysis is required to determine whether it can be applied to mental health and substance use disorder benefits.

The next step in the analysis is to determine whether the quantitative treatment limit is predominant. The federal rules state that a quantitative treatment limit is predominant if it is the most common or frequent of a type of limit or requirement. The predominant level of a quantitative treatment limit is the level that applies to more than one-half of medical/surgical benefits subject to that requirement in that classification.

As stated above, the Massachusetts Mental Health Parity Law allows for differences in coverage for biologically based diagnoses and non-biologically based diagnoses. The federal rules state that the definition of a particular benefit as "mental health" or "substance use disorder" regardless of whether the benefit is classified as biologically based or not, is subject to the federal parity requirements. Therefore, to the extent that non-biologically based conditions are defined by state law as "mental health" or "substance use" benefits, then they are subject to the parity requirements, and the benefit caps outlined in the state's law would likewise be subject to those federal requirements. If the individual health plan does not have similar benefit caps for medical and surgical benefits, then the benefit caps for mental health benefits would be prohibited under federal law.

EXAMPLE

FACTS: A plan generally imposes a combined annual $500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits Subject to Deductible	Total Benefits	Percentage Subject to Deductible
Inpatient, in-network	$1,800x	$2,000x	90
Inpatient, out-of-network	$1,000x	$1,000x	100
Outpatient, in-network	$1,400x	$2,000x	70
Outpatient, out-of-network	$1,880x	$2,000x	94
Emergency care	$300x	$500x	60

CONCLUSION: In this example, the two-thirds threshold of the "substantially all" standard is met with respect to each classification except emergency care, because in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the $500 deductible. Moreover, the $500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care for mental health and substance use disorder benefits cannot be subject to the $500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.[27]

EXAMPLE

FACTS: With respect to outpatient, in-network benefits, a plan imposes a $25 copayment for office visits and a 20 percent coinsurance requirement for outpatient surgery. The plan divides the outpatient, in-network classification into two subclassifications (in-network office visits and all other outpatient, in-network items and services). The plan or issuer does not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in either of these subclassifications that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in each subclassification.

CONCLUSION: In this example, the division of outpatient, in-network benefits into subclassifications for office visits and all other outpatient, in-network items and services does not violate the parity requirements.[28]

Nonquantitative Treatment Limits

The federal rules govern so-called nonquantitative treatment limits (NQTL). These are limits on the scope or duration of treatment that are not expressed numerically, such as prior authorization, medical management standards, formulary design, health care provider reimbursement, and network adequacy.[29] The rules in general state that for these practices, health plans are to apply these NQTLs no more stringently than treatment limits for medical and surgical benefits.[30] Under the federal rules, a plan is in compliance with MHPAEA if its mental health and substance use "processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable to, and applied no more stringently than," those on the medical/surgical side.[31]

EXAMPLE

FACTS: A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.

CONCLUSION: In this example, the plan complies with the rules of paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.[32]

Enforcement Oversight

The Massachusetts Division of Insurance (DOI) has the primary enforcement authority over state fully insured individual and group health plans. Other agencies that oversee health plan compliance with the parity laws include the Office of Medicaid and the Office of the Attorney General. The Office of Patient Protection (OPP) oversees and collects data relating to health plan external appeals.

Since the passage of the initial state Mental Health Parity Law, the DOI has undertaken several audits to ensure that health plans are complying with the law. The DOI requires that health plans provide members with adequate access to all mandated mental health provider types that offer the full range of mandated services, which includes a full range of outpatient, inpatient, and intermediate care services. Health plans must also ensure that they provide sufficient access to mental health providers, just as they do for other specialties, to avoid long waiting periods, and include the names of all contracted mental health providers in their provider directories.

In 2002, DOI, in conjunction with the Department of Public Health and the Department of Mental Health (DMH) issued a bulletin reminding health plans of their obligations to provide coverage for appropriate mental health services consistent with the Mental Health Parity Law.[33] The bulletin also stated that for a health plan to demonstrate good faith compliance with the Mental Health Parity Law and managed care laws, each carrier should have working procedures in place to provide assistance to members, monitor its network, and, in the event that no contracted provider is reasonably accessible to the patient, ensure that there is out-of-network treatment provided. Following the bulletin's release, the DOI conducted an audit of every health plan's mental health network and found that all MAHP member health plans are fully complying with the Mental Health Parity Law. MAHP's member health plans continue to comply with the requirements of the Mental Health Parity Law, including the expansions passed in 2008 at the state level.

As stated above, the federal rules grant states primary enforcement authority over the federal law. Massachusetts granted the DOI the authority to enforce the federal rules in 2012.[34] The DOI has promulgated regulations pursuant to its Chapter 224 authority.[35] The DOI's regulations require health plans to conduct an annual review of their administrative and other practices, including those delegated to subcontracting organizations, for compliance with the and federal laws and regulations. Following the review, health plans are required to submit a certification that the health plan is either in compliance with the laws or it is not.[36] Such certification is to be signed by both the health plan's CEO and CMO. In support of the annual certifications, the regulations require health plans to submit supporting information to demonstrate compliance with both the state Mental Health Parity Law and the federal Mental Health Parity law and regulations. Such information includes any financial and treatment limitations, medical necessity criteria, and authorization processes. The regulations include a requirement for health plans to notify their members of their rights under state and federal parity laws. The DOI additionally included a provision granting the right for consumers to submit complaints to the DOI alleging a health plan's noncompliance with state and/or federal parity laws. Finally, the DOI regulations set forth penalties for noncompliance with both laws, which could include completing a corrective action plan, fines, or even suspension or revocation of a health plan's accreditation or license. Massachusetts health plans have submitted certifications and accompanying information for the annual certifications.

With regard to federal oversight, the Department of Labor's Employee Benefits Security Administration (EBSA) conducts the Health Benefits Security Project (HBSP), which is a comprehensive national project to conduct investigations on health plans and services providers to detect violations. Investigations under HBSP include, among other things, a review to determine if the subject is in compliance with MHPAEA. In fiscal years 2010 through 2015, EBSA closed 3,118 civil investigations of health plans. Of those, 1,515 were subject to MHPAEA. Approximately 171 MHPAEA violations were cited. These violations included impermissible nonquantitative treatment limitations, impermissible quantitative treatment limitations, lifetime or annual dollar limits on mental health benefits, higher copayments with respect to mental health benefits than with respect to medical/surgical benefits, and inadequate disclosures to participants related to medical necessity determinations and reasons for benefit denial.[37]

Common Misconceptions

1. If my health plan contracts with a separate managed behavioral health organization (BHO), is that a violation of either the state or federal parity law?

Answer: No. State law does not prohibit health plans from contracting with a separate managed BHO. State law governs the relationship, holding health plans responsible for the BHO, and the DOI has the authority to oversee the relationship.[38] A federal FAQ addresses this question and states that MHPAEA does not require that health plans be organized in any particular way.[39]

2. Are prior authorization and other utilization management activities prohibited under the parity laws?

Answer: No. Chapter 176O of the Massachusetts General Laws governs health plan prior authorization and other utilization management activities. Health plans are required to implement prior authorization and other utilization management activities in a manner consistent with state and federal law. The DOI has not prohibited health plan utilization activities in its regulatory guidance clarifying state and federal parity rules.[40] Similarly, the federal rules do not include a per se prohibition of prior authorization or other utilization management practices for mental health and substance use disorder services insofar as they are comparable to those applied to medical/surgical benefits. To the extent that the processes used to develop and apply the criteria are comparable, prior authorization and other utilization management activities are not prohibited.

In addition, MHPAEA provides that the criteria used for medical necessity determinations with respect to mental health and substance use disorder benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, or beneficiary upon request. Massachusetts state law prohibits prior authorization and utilization management only for certain substance use disorder benefits.[41]

3. Do the parity laws require health plans to pay providers the same rate?

Answer: No. The federal rules state that health plans may apply various factors when developing provider reimbursement rates for both mental health and substance use disorder and medical/surgical services. These may include "service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience, and licensure of providers. The NQTL provisions require that these or other factors be applied comparably to, and no more stringently than, those applied with respect to medical/surgical services. Again, disparate results alone do not mean that the NQTLs in use fail to comply with these requirements."[42, 43]

4. Is it a violation of the parity laws if a health plan denies a mental health service?

Answer: On its face, no. Health plan denials, or adverse determinations, are made when a requested service does not meet current standards for medical necessity or clinical criteria. The final federal rules implementing MHPAEA require that carriers implement processes and protocols for NQTLs such as utilization management programs and medical necessity determinations for behavioral health service benefits that are comparable with medical/surgical benefits. The Final Rule further states that the processes, strategies, evidentiary standards, or other factors utilized in applying any limitations be comparable; however, it does not require that in each instance the outcomes of each such activity be the same. So long as the standard is the same for applying a NQTL and it is applied in a comparable manner, the health plan will be in compliance with the law.

5. If the Office of Patient Protection overturns a health plan's adverse determination, is that plan determination a violation of the parity laws?

Answer: No. The analysis above would also apply to this instance. The Office of Patient Protection contracts with independent agencies to review health plan adverse determinations and to make a decision to either uphold or overturn the health plan's decision. In reviewing the health plan's decision, the reviewing agency is looking at the medical evidence regarding the service in question and is not conducting an analysis as to the health plan's processes, strategies, evidentiary standards, or other factors utilized in making the decision and comparing to the medical surgical decisions. Therefore, any action by OPP's external review organizations to overturn a health plan's decision is not by itself an indicator of a violation of either state or federal law.

Quick Reference: Comparison State vs. Federal Parity Laws

Issue	State Parity Law	Federal Parity Law
Applicability	Health benefit plans provided by the GIC pursuant to Chapter 32A; Coverage offered pursuant to Chapters 175, 176A, 176B, and 176G of the General Laws (fully insured health plans).	ERISA group health plans and health insurers that provide coverage to group health plans; Medicaid and CHIP. The ACA expanded the scope of the federal Mental Health Parity Law to small groups and individuals, and requires coverage of mental healthand substance use disorder services as one of the 10 Essential Health Benefits in ACA Qualified Health Plans.
Scope	Coverage of biologically based disorders and non-biologically based disorders, as defined in the DSM	Does not require coverage of mental health and substance use disorder benefits but regulates the way they are offered. "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.
Enforcement	State Division of Insurance, Office of the Attorney General, Office of Medicaid, GIC	Massachusetts Division of Insurance (states), U.S. Department of Labor and the U.S. Department of Health and Human Services

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Footnotes

1 See DOI report: http://www.mass.gov/ocabr/docs/doi/managed-care/util/hmo-util-03-12.pdf. 2013 is the last full year of data. The analysis shows the trend over the years of high rates of utilization of mental health services in Massachusetts fully insured health plans.
2 Testimony by Joan Mikula, Commissioner, Massachusetts Department of Mental Health, to the Joint Committee on Ways and Means, February 22, 2016.
3 Chapter 80 of the Acts of 2000, An Act Relative to Mental Health Benefits, signed by the acting governor, May 2, 2000.
4 Center for Health Information and Analysis 2015 Annual Report, September 2015, pg. 24: http://www.chiamass.gov/assets/2015-annual-report/2015-Annual-Report.pdf.
5 Subsection (g) of Chapter 80 of the Acts of 2000.
6 Definition in original law: "licensed mental health professional" shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor or a licensed nurse mental health clinical specialist.
7 Chapter 301 of the Acts of 2012 (adding licensed marriage and family therapists), and Chapter 258 of the Acts of 2014 (adding licensed alcohol and drug counselors).
8 Chapter 321 of the Acts of 2008.
9 See Subsection(f) of Chapter 207 of the Acts of 2010: "This section shall not affect an obligation to provide services to an individual under an individualized family service plan, an individualized education program or an individualized service plan. Services related to autism spectrum disorder provided by school personnel under an individualized education program are not subject to reimbursement under this section."
10 Massachusetts General Laws Chapter 176O, Sections 13 and 14, Division of Insurance (DOI) regulations 211 CMR 52, and OPP regulations 958 CMR 3.000.
11 Section 12 of Chapter 176O, added by section 199 of Chapter 224 of the Acts of 2012.
12 78 Fed. Reg. 68,273 (November 13, 2013).
13 MHPAEA was enacted as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110-343) and amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code).
14 75 Fed.Reg. 5,410 (February 2, 2010).
15 78 Fed. Reg. 68,240 (November 13, 2013).
16 PHS Act section 2723(a).
17 SAMHSA: http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act.
18 SAMHSA: http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act.
19 78 Fed. Reg. 68,248 (November 13, 2013), citing 45 CFR 156.115(a)(3).
20 78 Fed. Reg. 68,248 (November 13, 2013).
21 The Final Rule allows for one further subclassification for outpatient office visits versus outpatient non-office visits.
22 75 Fed. Reg. 5,413 (February 2, 2010).
23 75 Fed. Reg. 5,413 (February 2, 2010).
24 75 Fed. Reg. 5,413 (February 2, 2010)
25 78 Fed. Reg. 68,247 (November 13, 2013).
26 The rules define "substantially all" as two-thirds and "predominant" as more than half of medical/surgical benefits in the same classification.
27 78 Fed. Reg. 68,271-68,272 (November 13, 2013).
28 78 Fed. Reg. 68,271 (November 13, 2013).
29 78 Fed. Reg. 68,241 (November 13, 2013).
30 78 Fed. Reg. 68,244 (November 13, 2013).
31 78 Fed. Reg. 68,422 (November 13, 2013).
32 78 Fed. Reg. 68,272 (November 13, 2013).
33 2002-07 Mental Health Benefits.
34 Section 23 of Chapter 224 of the Acts of 2012.
35 211 CMR 154.00.
36 See Bulletin 2013-06: Disclosure and Compliance Requirements for Carriers, and Process for Handling Complaints for Non-Compliance with Federal and State Mental Health and Substance Use Disorder Parity Laws, issued May 31, 2013.
37 http://www.dol.gov/ebsa/pdf/parityeducationreport.pdf.
38 M.G.L. Chapter 176O, Section 18.
39 Federal FAQ published May 9, 2012, Question 5.
40 See DOI Bulletins: 2009-04, Changes to State and Federal Mental Health Parity Laws (March 24, 2009); 2009-11, Access to Intermediate and Outpatient Mental Health & Substance Use Disorder Services (September 4, 2009); Bulletin 2013-06, Disclosure and Compliance Requirements for Carriers, and Process for Handling Complaints for Non-Compliance with Federal and State Mental Health and Substance Use Disorder Parity Laws (May 31, 2013).
41 See Chapter 258 of the Acts of 2014. Health plans are prohibited from requiring prior authorization for acute treatment services and clinical stabilization services, and for substance abuse treatment if the provider is certified or licensed by the department of public health.
42 78 Fed. Reg. 68246 (November 13, 2013).
43 The Final Rules did not adopt the recommendation made by some stakeholders that health care providers receive the same level of reimbursement across benefit categories.