SB

52

<TARGET><BILL>SB 52</BILL><SUBJECT>SB
52</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Interim: (May - Dec.)
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Senator_Bettye_Davis@legis.state.ak.us
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Office of Senator Bettye Davis

Hearing Package

SB 52 27-LS0081\A – The Alaska Mental Health Insurance Parity Act

TITLE: "An Act requiring health care insurers to provide coverage for treatment of mental health conditions, and requiring parity between health care insurance coverage for mental health, alcoholism, and substance abuse benefits and other medical care benefits; eliminating different treatment for mental health conditions from the minimum benefits of the state health insurance plan; removing an exclusion for mental health services or alcohol or drug abuse from the definition of 'basic health care services' in the law relating to health maintenance organizations; repealing a definition of 'mental health benefits' that excludes treatment of substance abuse or chemical dependency; and providing for an effective date."

Included in this hearing package are the following:

1. Sponsor Statement
2. Current version of SB 52, 27-LS0081\A
3. Sectional Summary
4. Fiscal Notes (by committee request)
5. Supportive Documents –
   - Legal Services Memo 9/10/2010
   - Diagnostic and Statistical Manual Of Mental Disorders
   - 42 USCS section 300gg-23
   - 42 USCS section 300gg-26
   - NCSL-State laws Mandating or Regulating Mental Health Benefits; updated February, 2009; reposted with additions February 11, 2010

Please anticipate in-person and teleconference testimony.

Thomas S. Obermeyer
Legislative Assistant 465-3762

Alaska State Legislature

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SPONSOR STATEMENT

This bill amends several sections of Alaska's health insurance code to require that health care insurers provide full "parity," *i.e.,* equal insurance coverage, or the same financial and treatment coverage for mental health conditions including alcohol and substance abuse as other physical illnesses. This bill expands on state compliance under HB 222 in 2009 with newly enacted federal parity law, the "*Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*" of 2008. That Act also applies to all Children's Health Insurance Programs and became effective April 1, 2009.

Historically, health insurers have been reluctant to cover mental health and substance abuse services on the same basis as general medical and surgical services. During the 1980s many states required insurers to provide coverage for mental health services and to offer freedom of choice among providers. However, concerns about the adequacy of this coverage persisted because insurers imposed increased cost sharing or restrictive benefit limits. This led to more federal and state intervention on behalf of consumers.

While current federal law does not mandate that group plans must provide mental health coverage, if they do, they must provide the same financial and treatment coverage offered for other physical illnesses. This bill differs from federal law in that it does mandate that "*a health care insurer which offers, issues for delivery, delivers, or renews a health care insurance plan to an employer or individual on a group or individual basis shall provide coverage for treatment of a mental health condition.*" Coverage of mental health conditions includes alcoholism and drug abuse as defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

This bill also requires parity with respect to all financial aspects including lifetime or annual limits, deductibles, copayments, coinsurances, benefits limitations with a $1,500 yearly maximum plus the deductible. It does not provide similar federal small business and business cost exemptions.

Self-funded health care plans are not state-regulated private "insurance" company plans and they usually are entirely exempt from state regulation because they are preempted by the federal ERISA law. Self-funded plans include the largest employers and the "Alaska Care" state health plan. The State Division of Insurance reportedly has not enforced insurance laws on the Alaska's union health trusts, and the Division's ability to do so is subject to legal debate. State laws generally do not apply to federally funded public programs such as Medicaid, Medicare and the Veterans Administration.

While the private insurers in Alaska have complained that insurance mandates only apply to about 40% of the insured in Alaska, voluntary compliance by large self-funded plans greatly increases this number. The self-funded state health plan historically has matched state mandates for private insurers, even though the state is not legally required to do. Currently, 46 states have passed some type of parity laws, the majority of which go beyond the federal mandate, including 28 that require full parity for mental health benefits. 38 states include coverage for substance abuse, alcohol or drug addiction.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB052
() Publish Date:

Identifier (file name): SB052-DHSS-BHMS-02-25-11
Title: Mental Health Care Insurance Benefit
Sponsor: Davis
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health
Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Melissa W Stone
Division: Behavioral Health
Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Phone 269-3410
Date/Time 2/14/11 2:30PM
Date 2/25/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB052

Analysis:

Health plans have often treated mental health and substance abuse treatment services differently than they have medical and surgical benefits. This bill defines medical care to include mental health care or care for an alcoholism or substance abuse disorder and requires parity between health care insurance coverage for mental health, alcoholism, substance abuse benefits and other medical care benefits in order to prohibit benefit or service limitations that are more restrictive or financially burdensome.

Assumptions:

The Division of Behavioral Health believes that although the State Medicaid programs under our supervision will experience some minor relief as services are covered through private insurance rather than the state's Medicaid Program, the effect would be offset by increased premiums for group health insurance. Responses to this increase would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered (including eliminating coverage for mental health benefits and/or substance benefits), and reductions in the scope of generosity of health insurance benefits, such as increased deductibles or higher copayments.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
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MEMORANDUM September 10, 2010

SUBJECT: Mental Health Parity (Work Order No. 27-LS0081\A)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey DCB
Legislative Counsel

This memorandum accompanies the draft bill relating to mental health parity that you requested. Please note the following issues that have come to my attention during drafting.

In 2009, the legislature repealed and reenacted AS 21.54.151 to require a health care insurer that offers a health care insurance plan in the group market to comply with the mental health or substance abuse benefit requirements established under 42 U.S.C. 300gg-5. Sec. 6, ch. 55, SLA 2009. However, 42 U.S.C. 300gg[1] of the Public Health Service Act, including 42 U.S.C. 300gg-5, which addresses mental health parity, was significantly amended and rearranged by the Patient Protection and Affordable Care Act.[2] 42 U.S.C. 300gg-5 was re-designated as 42 U.S.C. 300gg-26.[3] Copy enclosed. The Patient Protection and Affordable Care Act also amended former sec. 300gg-26 to include individual health insurance coverage under the policies.[4] The changes to 42 U.S.C. 300gg, et seq. are effective for plan years beginning on or after September 23, 2010.[5]

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[1] Part A of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg, et seq.) [see note preceding 42 U.S.C. 300gg].

[2] P.L. 111-148, Title 1, Subtitle A, Sec. 1001, 124 Stat. 130, March 23, 2010. It is not entirely clear whether this effective date was intended to apply to the amendments to sec. 300gg-26.

[3] See Explanatory note to current 42 U.S.C. 300gg-5.

[4] See Amendment note to 42 U.S.C. 300gg-26.

[5] P.L. 111-148, sec. 1004(a), 42 U.S.C. 300gg-11 note.

The current draft of the bill repeals and replaces AS 21.54.151. It removes the current reference adopting 42 U.S.C. 300gg-5 (the current reference) and eliminates the need to refer to 42 U.S.C. 300gg-26, the new reference as of September 23, 2010. However, the federal standards for parity for the treatment of mental health conditions under these federal statute sections remain effective. Subject to certain exceptions, the provisions of 42 U.S.C. 300gg et seq. do not supersede state law relating to health insurance issuers except to the extent that a state standard or requirement prevents the application of a requirement under 42 U.S.C. 300gg et seq. See 42 U.S.C. 300gg-23. Preemption; State flexibility; construction. Copy enclosed.

Note that the parity requirements for mental health benefits set out in AS 21.54.151(b), as repealed and reenacted by bill sec. 2, refer to "a mental health condition" but do not specifically refer to treatment for alcoholism or substance abuse. "Mental health condition" is defined in AS 21.54.151(c)(3) by reference to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. You should confirm that the designated manual adequately defines alcoholism or substance abuse as a mental health condition so that the parity provisions apply as you intend.

If I may be of further assistance, please advise.

DCB:ljw:plm
10-374.ljw

Enclosures

Thomas Obermeyer

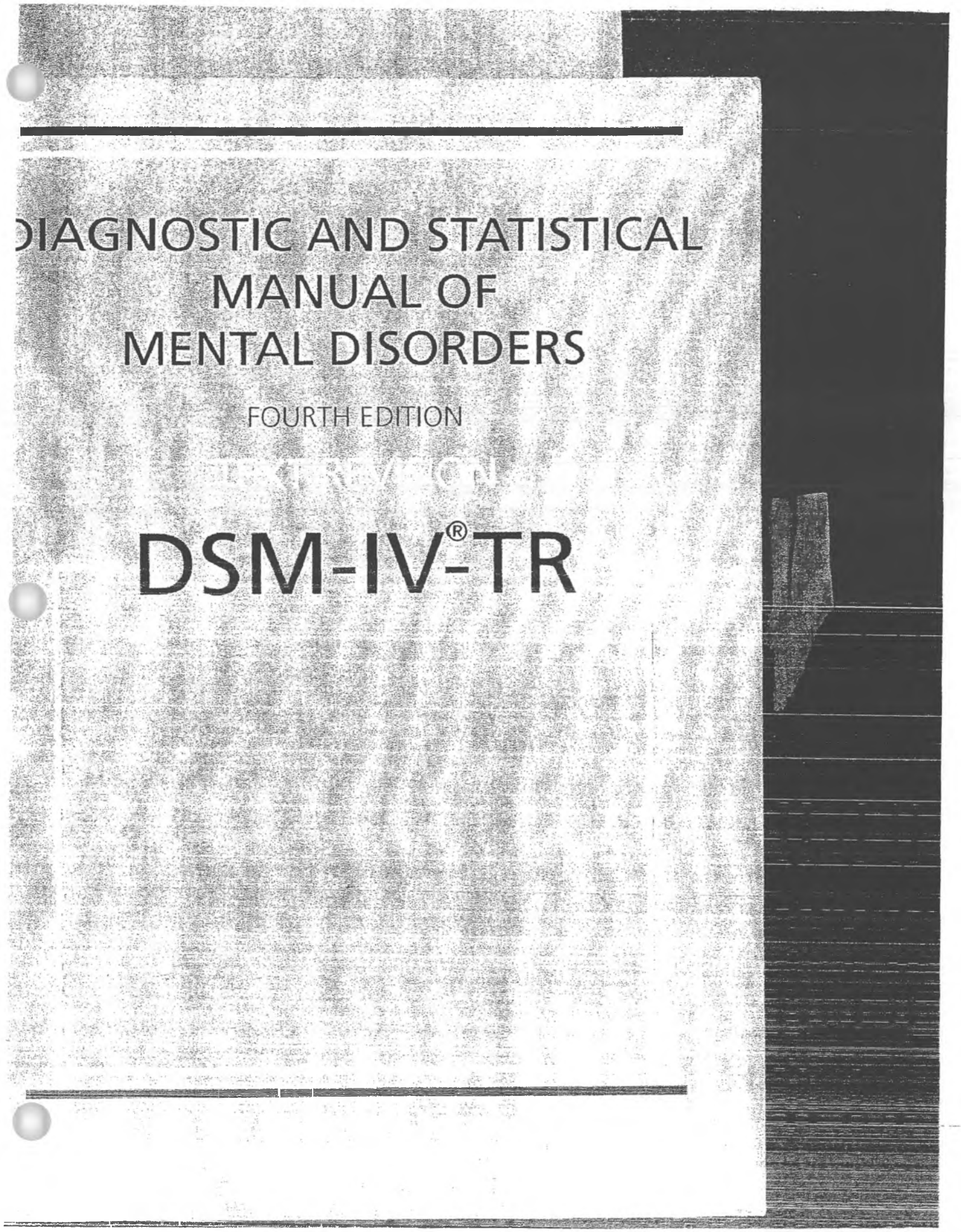
From: Nault, Richard L (HSS) [richard.nault@alaska.gov]
Sent: Friday, December 03, 2010 9:22 AM
To: Thomas Obermeyer
Cc: Toner, Stacy B (HSS)
Subject: RE: Mental health parity bill - definitions for 27-LS0081\A
Attachments: Substance Abuse_Dependence.pdf

Mr. Obermeyer,

Please find attached scanned pages of the DSM IV TR manual. You will note that pages 191 to 201 provide an overview of substance abuse disorders and subsequent pages list all of the various substance specific diagnoses. My approach was to, perhaps, provide more information than might be needed rather than less.

Do not hesitate to contact me if I can provide additional information,

Richard


DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FOURTH EDITION
DSM-IV®-TR

Substance-Related Disorders

The Substance-Related Disorders include disorders related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure. In this manual, the term *substance* can refer to a drug of abuse, a medication, or a toxin. The substances discussed in this section are grouped into 11 classes: alcohol; amphetamine or similarly acting sympathomimetics; caffeine; cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics. Although these 11 classes appear in alphabetical order, the following classes share similar features: alcohol shares features with the sedatives, hypnotics, and anxiolytics; and cocaine shares features with amphetamines or similarly acting sympathomimetics. Also included in this section are Polysubstance Dependence and Other or Unknown Substance-Related Disorders (which include most disorders related to medications or toxins).

Many prescribed and over-the-counter medications can also cause Substance-Related Disorders. Symptoms generally occur at high doses of the medication and usually disappear when the dosage is lowered or the medication is stopped. Medications that may cause Substance-Related Disorders include, but are not limited to, anesthetics and analgesics, anticholinergic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents, corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti-inflammatory medications, other over-the-counter medications, antidepressant medications, and disulfiram.

Exposure to a wide range of other chemical substances can also lead to the development of a Substance-Related Disorder. Toxic substances that may cause Substance-Related Disorders include, but are not limited to, heavy metals (e.g., lead or aluminum), rat poisons containing strychnine, pesticides containing nicotine, or acetylcholinesterase inhibitors, nerve gases, ethylene glycol (antifreeze), carbon monoxide, and carbon dioxide. The volatile substances (e.g., fuel, paint) are classified as "inhalants" (see p. 257) if they are used for the purpose of becoming intoxicated; they are considered "toxins" if exposure is accidental or part of intentional poisoning. Impairments in cognition or mood are the most common symptoms associated with toxic substances, although anxiety, hallucinations, delusions, or seizures can also result. Symptoms usually disappear when the individual is no longer exposed to the substance, but resolution of symptoms can take weeks or months and may require treatment.

The Substance-Related Disorders are divided into two groups: the Substance Use Disorders (Substance Dependence and Substance Abuse) and the Substance-Induced Disorders (Substance Intoxication, Substance Withdrawal, Substance-Induced Delirium, Substance-Induced Persisting Dementia, Substance-Induced Persisting Am-

nestic Disorder, Substance-Induced Psychotic Disorder, Substance-Induced Mood Disorder, Substance-Induced Anxiety Disorder, Substance-Induced Sexual Dysfunction, and Substance-Induced Sleep Disorder). The section begins with the text and criteria sets for Substance Dependence, Abuse, Intoxication, and Withdrawal that are applicable across classes of substances. This is followed by general comments concerning associated features; culture, age, and gender features; course; impairment and complications; familial pattern; differential diagnosis; and recording procedures that apply to all substance classes. The remainder of the section is organized by class of substance and describes the specific aspects of Dependence, Abuse, Intoxication, and Withdrawal for each of the 11 classes of substances. It should be noted that the Prevalence sections of the substance-specific texts contain survey data indicating rates of substance use in various age groups, as well as the lifetime and 1-year prevalence of Dependence and Abuse. To facilitate differential diagnosis, the text and criteria for the remaining Substance-Induced Disorders are included in the sections of the manual with disorders with which they share phenomenology (e.g., Substance-Induced Mood Disorder is included in the "Mood Disorders" section). The diagnoses associated with each specific group of substances are shown in Table 1.

Substance Use Disorders

Substance Dependence

Features

The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance Dependence can be applied to every class of substances except caffeine. The symptoms of Dependence are similar across the various categories of substances, but for certain classes some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for Hallucinogen Dependence). Although not specifically listed as a criterion item, "craving" (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence. Dependence is defined as a cluster of three or more of the symptoms listed below occurring at any time in the same 12-month period.

Tolerance (Criterion 1) is the need for greatly increased amounts of the substance to achieve intoxication (or the desired effect) or a markedly diminished effect with continued use of the same amount of the substance. The degree to which tolerance develops varies greatly across substances. Furthermore, for a specific drug, varied degrees of tolerance may develop for its different central nervous system effects. For example, for opioids, tolerance to respiratory depression and tolerance to analgesia develop at different rates. Individuals with heavy use of opioids and stimulants can

Table 1. Diagnoses associated with class of substances

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Table 1. Diagnoses associated with class of substances

	Dependence	Abuse	Intoxication	Withdrawal	Intoxication Delirium	Withdrawal Delirium	Dementia	Amnestic Disorder	Psychotic Disorders	Mood Disorders	Anxiety Disorders	Sexual Dysfunctions	Sleep Disorders
Alcohol	X	X	X	X	I	W	P	P	I/W	I/W	I/W	I	I/W
Amphetamines	X	X	X	X	I				I	I/W	I	I	I/W
Caffeine			X								I		I
Cannabis	X	X	X		I				I		I		
Cocaine	X	X	X	X	I				I	I/W	I/W	I	I/W
Hallucinogens	X	X	X		I				P*	I	I		
Inhalants	X	X	X		I		P		I	I	I		
Nicotine	X			X									
Opioids	X	X	X	X	I				I	I		I	I/W
Phencyclidine	X	X	X		I				I	I	I		
Sedatives, hypnotics, or anxiolytics	X	X	X	X	I	W	P	P	I/W	I/W	W	I	I/W
Polysubstance	X												
Other	X	X	X	X	I	W	P	P	I/W	I/W	I/W	I	I/W

*Also Hallucinogen Persisting Perception Disorder (Flashbacks).

Note: X, I, W, I/W, or P indicates that the category is recognized in DSM-IV. In addition, *I* indicates that the specifier With Onset During Intoxication may be noted for the category (except for Intoxication Delirium); *W* indicates that the specifier With Onset During Withdrawal may be noted for the category (except for Withdrawal Delirium); and *I/W* indicates that either With Onset During Intoxication or With Onset During Withdrawal may be noted for the category. *P* indicates that the disorder is Persisting.

develop substantial (e.g., 10-fold) levels of tolerance, often to a dosage that would b lethal to a nonuser. Alcohol tolerance can also be pronounced, but is usually less e› treme than for amphetamine. Many individuals who smoke cigarettes consume mor than 20 cigarettes a day, an amount that would have produced symptoms of toxicit when they first started smoking. Individuals with heavy use of cannabis or phencycl dine (PCP) are generally not aware of having developed tolerance (although it ha been demonstrated in animal studies and in some individuals). Tolerance may be dif ficult to determine by history alone when the substance used is illegal and perhap mixed with various diluents or with other substances. In such situations, laborator tests may be helpful (e.g., high blood levels of the substance coupled with little evi dence of intoxication suggest that tolerance is likely). Tolerance must also be distin guished from individual variability in the initial sensitivity to the effects of particula substances. For example, some first-time drinkers show very little evidence of intox ication with three or four drinks, whereas others of similar weight and drinking his tories have slurred speech and incoordination.

Withdrawal (Criterion 2a) is a maladaptive behavioral change, with physiologica and cognitive concomitants, that occurs when blood or tissue concentrations of a sub stance decline in an individual who had maintained prolonged heavy use of the sub stance. After developing unpleasant withdrawal symptoms, the person is likely t take the substance to relieve or to avoid those symptoms (Criterion 2b), typically us ing the substance throughout the day beginning soon after awakening. Withdrawa symptoms, which are generally the opposite of the acute effects of the substance, var greatly across the classes of substances, and separate criteria sets for Withdrawal ar provided for most of the classes. Marked and generally easily measured physiologi cal signs of withdrawal are common with alcohol, opioids, and sedatives, hypnotics and anxiolytics. Withdrawal signs and symptoms are often present, but may be les apparent, with stimulants such as amphetamines and cocaine, as well as with nicotin and cannabis. No significant withdrawal is seen even after repeated use of hallucino gens. Withdrawal from phencyclidine and related substances has not yet been de scribed in humans (although it has been demonstrated in animals). Neither tolerance nor withdrawal is necessary or sufficient for a diagnosis of Substance Dependence However, for most classes of substances, a past history of tolerance or withdrawal i associated with a more severe clinical course (i.e., an earlier onset of Dependence higher levels of substance intake, and a greater number of substance-related prob lems). Some individuals (e.g., those with Cannabis Dependence) show a pattern o compulsive use without obvious signs of tolerance or withdrawal. Conversely, som general medical and postsurgical patients without Opioid Dependence may develo a tolerance to prescribed opioids and experience withdrawal symptoms withou showing any signs of compulsive use. The specifiers With Physiological Dependenc and Without Physiological Dependence are provided to indicate the presence or ab sence of tolerance or withdrawal.

The following items describe the pattern of compulsive substance use that is char acteristic of Dependence. The individual may take the substance in larger amounts o over a longer period than was originally intended (e.g., continuing to drink until se verely intoxicated despite having set a limit of only one drink) (Criterion 3). The in dividual may express a persistent desire to cut down or regulate substance use. Often there have been many unsuccessful efforts to decrease or discontinue use (Criterion 4)

he individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 5). In some instances of Substance Dependence, virtually all of the person's daily activities revolve around the substance. mportant social, occupational, or recreational activities may be given up or reduced ecause of substance use (Criterion 6). The individual may withdraw from family activities and hobbies in order to use the substance in private or to spend more time vith substance-using friends. Despite recognizing the contributing role of the substance to a psychological or physical problem (e.g., severe depressive symptoms or amage to organ systems), the person continues to use the substance (Criterion 7). he key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite having evidence of the difficulty it is causing.

pecifiers

olerance and withdrawal may be associated with a higher risk for immediate general medical problems and a higher relapse rate. Specifiers are provided to note their resence or absence:

With Physiological Dependence. This specifier should be used when Substance Dependence is accompanied by evidence of tolerance (Criterion 1) or withdrawal (Criterion 2).

Without Physiological Dependence. This specifier should be used when there is no evidence of tolerance (Criterion 1) or withdrawal (Criterion 2). In these individuals, Substance Dependence is characterized by a pattern of compulsive use (at least three items from Criteria 3–7).

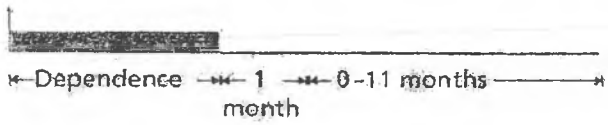
Course Specifiers

ix course specifiers are available for Substance Dependence. The four Remission pecifiers can be applied only after none of the criteria for Substance Dependence or Substance Abuse have been present for at least 1 month. For those criteria that require ecurrent problems, a remission specifier can apply only if no aspect of the criterion as been present (e.g., one incident of driving while intoxicated would suffice to disqualify the individual from being considered in remission). The definition of these our types of Remission is based on the interval of time that has elapsed since the cesation of Dependence (Early versus Sustained Remission) and whether there is continued presence of one or more of the items included in the criteria sets for Dependence or Abuse (Partial versus Full Remission). Because the first 12 months following Dependence is a time of particularly high risk for relapse, this period is designated Early Remission. After 12 months of Early Remission have passed without relapse to Dependence, the person enters into Sustained Remission. For both Early Remission and Sustained Remission, a further designation of Full is given if no criteria for Dependence or Abuse have been met during the period of remission; a designation of Partial is given if at least one of the criteria for Dependence or Abuse has been met, intermittently or continuously, during the period of remission. The differentiation of Sustained Full Remission from recovered (no current Substance Use Dis-

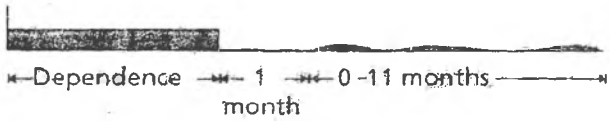
order) requires consideration of the length of time since the last period of disturbance, the total duration of the disturbance, and the need for continued evaluation. If, after a period of remission or recovery, the individual again becomes dependent, the application of the Early Remission specifier requires that there again be at least 1 month in which no criteria for Dependence or Abuse are met. Two additional specifiers have been provided: On Agonist Therapy and In a Controlled Environment. For an individual to qualify for Early Remission after cessation of agonist therapy or release from a controlled environment, there must be a 1-month period in which none of the criteria for Dependence or Abuse are met.

The following Remission specifiers can be applied only after no criteria for Dependence or Abuse have been met for at least 1 month. Note that these specifiers do not apply if the individual is on agonist therapy or in a controlled environment (see below).

Early Full Remission. This specifier is used if, for at least 1 month, but for less than 12 months, no criteria for Dependence or Abuse have been met.



Early Partial Remission. This specifier is used if, for at least 1 month, but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).



Sustained Full Remission. This specifier is used if none of the criteria for Dependence or Abuse have been met at any time during a period of 12 months or longer.

Sustained Partial Remission. This specifier is used if full criteria for Dependence have not been met for a period of 12 months or longer; however, one or more criteria for Dependence or Abuse have been met.

The following specifiers apply if the individual is on agonist therapy or in a controlled environment:

On Agonist Therapy. This specifier is used if the individual is on a prescribed agonist medication such as methadone and no criteria for Dependence or Abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from, the agonist). This category also applies to those being treated for Dependence using a partial agonist or an agonist/antagonist.

In a Controlled Environment. This specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted, and no criteria for Dependence or Abuse have been met for at least the past month. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, or locked hospital units.

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Criteria for Substance Dependence *(continued)*

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)
Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

Course specifiers (see text for definitions):

Early Full Remission
Early Partial Remission
Sustained Full Remission
Sustained Partial Remission
On Agonist Therapy
In a Controlled Environment

Substance Abuse

Features

The essential feature of Substance Abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an Abuse criterion to be met, the substance-related problem must have occurred repeatedly during the same 12-month period or been persistent. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems (Criterion A). Unlike the criteria for Substance Dependence, the criteria for Substance Abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeated use. A diagnosis of Substance Abuse is preempted by the diagnosis of Substance Dependence if the individual's pattern of substance use has ever met the criteria for Dependence for that class of substances (Criterion B). Although a diagnosis of Substance Abuse is more likely in individuals who have only recently started taking the substance, some individuals continue to have substance-related adverse social consequences over a long period of time without developing evidence of Substance Dependence. The category of Substance Abuse does not apply to caffeine and nicotine. The term *abuse* should be applied only to a pattern of substance use that meets the criteria for this disorder; the term should not be used as a synonym for "use," "misuse," or "hazardous use."

The individual may repeatedly demonstrate intoxication or other substance-related symptoms when expected to fulfill major role obligations at work, school, or home (Criterion A1). There may be repeated absences or poor work performance related to recurrent hangovers. A student might have substance-related absences, suspensions, or expulsions from school. While intoxicated, the individual may neglect children or household duties. The person may repeatedly be intoxicated in situations that are

physically hazardous (e.g., while driving a car, operating machinery, or engaging in risky recreational behavior such as swimming or rock climbing) (Criterion A2). There may be recurrent substance-related legal problems (e.g., arrests for disorderly conduct, assault and battery, driving under the influence) (Criterion A3). The person may continue to use the substance despite a history of undesirable persistent or recurrent social or interpersonal consequences (e.g., marital difficulties or divorce, verbal or physical fights) (Criterion A4).

Criteria for Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance-Induced Disorders

Substance Intoxication

Diagnostic Features

The essential feature of Substance Intoxication is the development of a reversible substance-specific syndrome due to the recent ingestion of (or exposure to) a substance (Criterion A). The clinically significant maladaptive behavioral or psychological changes associated with intoxication (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, impaired social or occupational functioning) are due to the direct physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance (Criterion B). The symptoms are not due to a general medical condition and are not better accounted for by another

mental disorder (Criterion C). Substance Intoxication is often associated with Su stance Abuse or Dependence. This category does not apply to nicotine. Evidence f recent intake of the substance can be obtained from the history, physical examinati (e.g., smell of alcohol on the breath), or toxicological analysis of body fluids (e. urine or blood).

The most common changes involve disturbances of perception, wakefulness, a tention, thinking, judgment, psychomotor behavior, and interpersonal behavior. Th specific clinical picture in Substance Intoxication varies dramatically among indivi uals and also depends on which substance is involved, the dose, the duration or chr nicity of dosing, the person's tolerance for the substance, the period of time since th last dose, the expectations of the person as to the substance's effects, and the enviro ment or setting in which the substance is taken. Short-term or "acute" intoxicatior may have different signs and symptoms from sustained or "chronic" intoxication For example, moderate cocaine doses may initially produce gregariousness, bu social withdrawal may develop if such doses are frequently repeated over days c weeks.

Different substances (sometimes even different substance classes) may produc identical symptoms. For example, Amphetamine and Cocaine Intoxication can bot present with grandiosity and hyperactivity, accompanied by tachycardia, pupillar dilation, elevated blood pressure, and perspiration or chills. Also, alcohol and sub stances from the sedative, hypnotic, or anxiolytic class produce similar symptoms o intoxication.

When used in the physiological sense, the term *intoxication* is broader than Sub stance Intoxication as defined here. Many substances may produce physiological o psychological changes that are not necessarily maladaptive. For example, an individ ual with tachycardia from excessive caffeine use has a physiological intoxication, bu if this is the only symptom in the absence of maladaptive behavior, the diagnosis o Caffeine Intoxication would not apply. The maladaptive nature of a substance induced change in behavior depends on the social and environmental context. The maladaptive behavior generally places the individual at significant risk for adverse effects (e.g., accidents, general medical complications, disruption in social and family relationships, vocational or financial difficulties, legal problems). Signs and symptoms of intoxication may sometimes persist for hours or days beyond the time when the substance is detectable in body fluids. This may be due to continuing low concentrations of the substance in certain areas of the brain or to a "hit and run" effect in which the substance alters a physiological process, the recovery of which takes longer than the time for elimination of the substance. These longer-term effects of intoxication must be distinguished from withdrawal (i.e., symptoms initiated by a decline in blood or tissue concentrations of a substance).

Criteria for Substance Intoxication

A. The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. **Note:** Different substances may produce similar or identical syndromes.

B. Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, impaired social or occupational functioning) and develop during or shortly after use of the substance.

C. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Substance Withdrawal

Diagnostic Features

The essential feature of Substance Withdrawal is the development of a substance-specific maladaptive behavioral change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use (Criterion A). The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (Criterion C). Withdrawal is usually, but not always, associated with Substance Dependence (see p. 192). Most (perhaps all) individuals with Withdrawal have a craving to readminister the substance to reduce the symptoms. The diagnosis of Withdrawal is recognized for the following groups of substances: alcohol; amphetamines and other related substances; cocaine; nicotine; opioids; and sedatives, hypnotics, or anxiolytics. The signs and symptoms of Withdrawal vary according to the substance used, with most symptoms being the opposite of those observed in Intoxication with the same substance. The dose and duration of use and other factors such as the presence or absence of additional illnesses also affect withdrawal symptoms. Withdrawal develops when doses are reduced or stopped, whereas signs and symptoms of Intoxication improve (gradually in some cases) after dosing stops.

Specify type: Labile Type/Disinhibited Type/Aggressive Type/Apathetic Type/Paranoid Type/Other Type/Combined Type/Unspecified Type

293.9 Mental Disorder NOS Due to . . . *[Indicate the General Medical Condition]* (190)

Substance-Related Disorders (191)

The following specifiers apply to Substance Dependence as noted:

[a]With Physiological Dependence/Without Physiological Dependence

[b]Early Full Remission/Early Partial Remission/Sustained Full Remission/Sustained Partial Remission

[c]In a Controlled Environment

[d]On Agonist Therapy

The following specifiers apply to Substance-Induced Disorders as noted:

[I]With Onset During Intoxication/[W]With Onset During Withdrawal

ALCOHOL-RELATED DISORDERS (212)

Alcohol Use Disorders (213)

303.90 Alcohol Dependence[a,b,c] (213)

305.00 Alcohol Abuse (214)

Alcohol-Induced Disorders (214)

303.00 Alcohol Intoxication (214)

291.81 Alcohol Withdrawal (215)
Specify if: With Perceptual Disturbances

291.0 Alcohol Intoxication Delirium (143)

291.0 Alcohol Withdrawal Delirium (143)

291.2 Alcohol-Induced Persisting Dementia (168)

291.1 Alcohol-Induced Persisting Amnestic Disorder (177)

291.x Alcohol-Induced Psychotic Disorder (338)

.5 With Delusions[I,W]

.3 With Hallucinations[I,W]

291.89 Alcohol-Induced Mood Disorder[I,W] (405)

291.89 Alcohol-Induced Anxiety Disorder[I,W] (479)

291.89 Alcohol-Induced Sexual Dysfunction[I] (562)

291.89 Alcohol-Induced Sleep Disorder[I,W] (655)

291.9 Alcohol-Related Disorder NOS (223)

AMPHETAMINE (OR AMPHETAMINE-LIKE)-RELATED DISORDERS (223)

Amphetamine Use Disorders (224)

304.40 Amphetamine Dependence[a,b,c] (224)

305.70 Amphetamine Abuse (225)

Amphetamine-Induced Disorders (226)

292.89 Amphetamine Intoxication (226)
Specify if: With Perceptual Disturbances

292.0 Amphetamine Withdrawal (227)

292.81 Amphetamine Intoxication Delirium (143)

292.xx Amphetamine-Induced Psychotic Disorder (338)

.11 With Delusions[I]

.12 With Hallucinations[I]

292.84 Amphetamine-Induced Mood Disorder[I,W] (405)

292.89 Amphetamine-Induced Anxiety Disorder[I] (479)

292.89 Amphetamine-Induced Sexual Dysfunction[I] (562)

292.89 Amphetamine-Induced Sleep Disorder[I,W] (655)

292.9 Amphetamine-Related Disorder NOS (231)

292.82 Inhalant-Induced Persisting Dementia (168)
292.xx Inhalant-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Inhalant-Induced Mood Disorder[I] (405)
292.89 Inhalant-Induced Anxiety Disorder[I] (479)
292.9 Inhalant-Related Disorder NOS (263)

NICOTINE-RELATED DISORDERS (264)

Nicotine Use Disorder (264)
305.1 Nicotine Dependence[a,b] (264)

Nicotine-Induced Disorder (265)
292.0 Nicotine Withdrawal (265)
292.9 Nicotine-Related Disorder NOS (269)

OPIOID-RELATED DISORDERS (269)

Opioid Use Disorders (270)
304.00 Opioid Dependence[a,b,c,d] (270)
305.50 Opioid Abuse (271)

Opioid-Induced Disorders (271)
292.89 Opioid Intoxication (271)
Specify if: With Perceptual Disturbances
292.0 Opioid Withdrawal (272)
292.81 Opioid Intoxication Delirium (143)
292.xx Opioid-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Opioid-Induced Mood Disorder[I] (405)
292.89 Opioid-Induced Sexual Dysfunction[I] (562)
292.89 Opioid-Induced Sleep Disorder[I,W] (655)
292.9 Opioid-Related Disorder NOS (277)

PHENCYCLIDINE (OR PHENCYCLIDINE-LIKE)–RELATED DISORDERS (278)

Phencyclidine Use Disorders (279)
304.60 Phencyclidine Dependence[b,c] (279)
305.90 Phencyclidine Abuse (279)

Phencyclidine-Induced Disorders (280)
292.89 Phencyclidine Intoxication (280)
Specify if: With Perceptual Disturbances
292.81 Phencyclidine Intoxication Delirium (143)
292.xx Phencyclidine-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Phencyclidine-Induced Mood Disorder[I] (405)
292.89 Phencyclidine-Induced Anxiety Disorder[I] (479)
292.9 Phencyclidine-Related Disorder NOS (283)

SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DISORDERS (284)

Sedative, Hypnotic, or Anxiolytic Use Disorders (285)
304.10 Sedative, Hypnotic, or Anxiolytic Dependence[a,b,c] (285)
305.40 Sedative, Hypnotic, or Anxiolytic Abuse (286)

Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders (286)
292.89 Sedative, Hypnotic, or Anxiolytic Intoxication (286)
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal (287)
Specify if: With Perceptual Disturbances
292.81 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium (143)
292.81 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (143)

92.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia (168)
92.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder (177)
92.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder (338)
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
92.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder[I,W] (405)
92.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder[W] (479)
92.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction[I] (562)
92.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder[I,W] (655)
92.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS (293)

'OLYSUBSTANCE-RELATED)ISORDER (293)

04.80 Polysubstance Dependence[a,b,c,d] (293)

)THER (OR UNKNOWN) SUBSTANCE-RELATED DISORDERS 294)

)ther (or Unknown) Substance Use Disorders (295)

04.90 Other (or Unknown) Substance Dependence[a,b,c,d] (192)
05.90 Other (or Unknown) Substance Abuse (198)

)ther (or Unknown) Substance-nduced Disorders (295)

92.89 Other (or Unknown) Substance Intoxication (199)
Specify if: With Perceptual Disturbances
292.0 Other (or Unknown) Substance Withdrawal (201)
Specify if: With Perceptual Disturbances
292.81 Other (or Unknown) Substance-Induced Delirium (143)
292.82 Other (or Unknown) Substance-Induced Persisting Dementia (168)
292.83 Other (or Unknown) Substance-Induced Persisting Amnestic Disorder (177)
292.xx Other (or Unknown) Substance-Induced Psychotic Disorder (338)
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Other (or Unknown) Substance-Induced Mood Disorder[I,W] (405)
292.89 Other (or Unknown) Substance-Induced Anxiety Disorder[I,W] (479)
292.89 Other (or Unknown) Substance-Induced Sexual Dysfunction[I] (562)
292.89 Other (or Unknown) Substance-Induced Sleep Disorder[I,W] (655)
292.9 Other (or Unknown) Substance-Related Disorder NOS (295)

Schizophrenia and Other Psychotic Disorders (297)

295.xx Schizophrenia (298)
The following Classification of Longitudinal Course applies to all subtypes of Schizophrenia:

Episodic With Interepisode Residual Symptoms (*specify if:* With Prominent Negative Symptoms)/ Episodic With No Interepisode Residual Symptoms

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42 USCS § 300gg-23

TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A. THE PUBLIC HEALTH SERVICE
REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE
INDIVIDUAL AND GROUP MARKET REFORMS
EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

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42 USCS § 300gg-23

§ 300gg-23. Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers.

(1) In general. Subject to paragraph (2) and except as provided in subsection (b), this part [42 USCS §§ 300gg et seq.] and part C [42 USCS §§ 300gg-91 et seq.] insofar as it relates to this part [42 USCS §§ 300gg et seq.] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part [42 USCS §§ 300gg et seq.].

(2) Continued preemption with respect to group health plans. Nothing in this part [42 USCS §§ 300gg et seq.] shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 [29 USCS § 1144] with respect to group health plans.

(b) Special rules in case of portability requirements.

(1) In general. Subject to paragraph (2), the provisions of this part [42 USCS §§ 300gg et seq.] relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) Exceptions. Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part [42 USCS §§ 300gg et seq.] do not supersede any provision of State law to the extent that such provision--

(i) substitutes for the reference to "6-month period" in section 2701(a)(1) [42 USCS § 300gg(a)(1)] a reference to any shorter period of time;

(ii) substitutes for the reference to "12 months" and "18 months" in section 2701(a)(2) [42 USCS § 300gg(a)(2)] a reference to any shorter period of time;

(iii) substitutes for the references to "63" days in sections 2701(c)(2)(A) and 2701(d)(4)(A) [42 USCS § 300gg(c)(2)(A), (d)(4)(A)] a reference to any greater number of days;

(iv) substitutes for the reference to "30-day period" in sections 2701(b)(2) and 2701(d)(1) [42 USCS § 300gg(b)(2), (d)(1)] a reference to any greater period;

(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) [42 USCS § 300gg(d)] or expands the exceptions described in such section;

(vi) requires special enrollment periods in addition to those required under section 2701(f) [42 USCS § 300gg(f)]; or

(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B) [42 USCS § 300gg(g)(1)(B)].

(c) Rules of construction. Nothing in this part [42 USCS §§ 300gg et seq.] (other than section 2704 [42 USCS §

300gg-4]) shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) Definitions. For purposes of this section--

(1) State law. The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) State. The term "State" includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

History:

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart 2[4][3], § 2724 [2737] [2723], as added Aug. 21, 1996, P.L. 104-191, Title I, Subtitle A, Part 1, § 102(a), 110 Stat. 1971; Sept. 26, 1996, P.L. 104-204, Title VI, § 604(a)(2), (b)(2), 110 Stat. 2939, 2941; March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(4), Subtitle G, § 1563(c)(14) [1562(c)(14)], Title X, Subtitle A, § 10107(b)(1), 124 Stat. 130, 269, 911.)

History; Ancillary Laws and Directives:

1. Amendments
2. Redesignation
3. Other provisions

1. Amendments:

1996. Act Sept. 26, 1996 (applicable with respect to group health plans for plan years beginning on or after 1/1/98, which appears as 42 USCS § 300gg-4 note), in subsec. (c), inserted "(other than section 2704)".

2010. Act March 23, 2010, in subsec. (a)(1), inserted "individual or".

2. Redesignation:

Subpart 3 of Part A of Title XXVII of Act July 1, 1944, ch 373, was redesignated Subpart 4 of such Part by Act Sept. 26, 1996, P.L. 104-204, Title VI, § 604(a)(2), 110 Stat. 2939. It was further redesignated Subpart 2 of such Part by Act March 23, 2010, P.L. 111-148, Title I, Subtitle G, § 1562(c)(11), 124 Stat. 268.

This section, enacted as § 2723 of Part A of Title XXVII of Act July 1, 1944, ch 373, was redesignated § 2737 of such Part by Act March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(4), 124 Stat. 130. It was further redesignated § 2724 of such Part by § 1562(c)(14)(B) of the 2010 Act.

Section 1562 of Act March 23, 2010, P.L. 111-148, which amended this section, was redesignated § 1563 of such Act by § 10107(b)(1) of the Act.

3. Other provisions:

Applicability of section. Subject to certain exceptions, Part A of title XXVII of the Public Health Service Act (42 USCS §§ 300gg et seq.) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, pursuant to § 102(c) of Act Aug. 21, 1996, P.L. 104-191, which appears as 42 USCS § 300gg note.

Notes:

Research Guide:

Law Review Articles:

Standard HIPAA Order in Civil Actions. 65 Ala Law 332. September 2004.

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42 USCS § 300gg-26

TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A. THE PUBLIC HEALTH SERVICE
REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE
INDIVIDUAL AND GROUP MARKET REFORMS
EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

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42 USCS § 300gg-26

§ 300gg-26. Parity in mental health and substance use disorder benefits

(a) In general.

(1) Aggregate lifetime limits. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits--

(A) No lifetime limit. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan or coverage shall either--

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

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

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits--

(A) No annual limit. If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit. If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either--

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

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

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the

Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations.

(A) In general. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage 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.

(B) Definitions. In this paragraph:

(i) Financial requirement. The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) 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) of 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.

(5) Out-of-network providers. 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.

(b) Construction. Nothing in this section shall be construed--

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions.

(1) Small employer exemption. This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 2791(e)(4) [42 USCS § 300gg-91(e)(4)], except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption.

(A) In general. With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage. With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be--

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries. Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group

health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations. If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification.

(i) In general. A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement. A notification to the Secretary under clause (i) shall include--

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality. A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes--

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies. To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Separate application to each option offered. In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions. For purposes of this section--

(1) Aggregate lifetime limit. The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit. The term "annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits. The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

(4) Mental health benefits. The term "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.

(5) Substance use disorder benefits. The term "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.

History:

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart 2, § 2706 [2705], as added Sept. 26, 1996, P.L. 104-204, Title VII, § 703(a), 110 Stat. 2947; Jan. 10, 2002, P.L. 107-116, Title VII, § 701(b), 115 Stat. 2228; Dec. 2, 2002, P.L. 107-313, § 2(b), 116 Stat. 2457; Dec. 19, 2003, P.L. 108-197, § 2(b), 117 Stat. 2898; Oct. 4, 2004, P.L. 108-311, Title III, § 302(c), 118 Stat. 1179; Dec. 30, 2005, P.L. 109-151, § 1(b), 119 Stat. 2886; Dec. 20, 2006, P.L. 109-432, Div A, Title I, § 115(c), 120 Stat. 2941; June 17, 2008, P.L. 110-245, Title IV, § 401(c), 122 Stat. 1650; Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(b), (g)(2), 122 Stat. 3885, 3892; March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(2), Subtitle G, § 1563(c)(4) [1562(c)(4)], Title X, Subtitle A, § 10107(b)(1), 124 Stat. 130, 265, 911.)

History; Ancillary Laws and Directives:

1. Explanatory notes
2. Amendments
3. Redesignation
4. Other provisions

∓ 1. Explanatory notes:
This section formerly appeared as 42 USCS § 300gg-5.

∓ 2. Amendments:

2002. Act Jan. 10, 2002, in subsec. (f), substituted "December 31, 2002" for "September 30, 2001".
Act Dec. 2, 2002, in subsec. (f), substituted "December 31, 2003" for "December 31, 2002".

2003. Act Dec. 19, 2003, in subsec. (f), substituted "December 31, 2004" for "December 31, 2003".

2004. Act Oct. 4, 2004 (effective on enactment, as provided by § 302(d) of such Act, which appears as 26 USCS § 9812 note), in subsec. (f), substituted "after December 31, 2005" for "on or after December 31, 2004".

2005. Act Dec. 30, 2005, in subsec. (f), substituted "December 31, 2006" for "December 31, 2005".

2006. Act Dec. 20, 2006, in subsec. (f), substituted "2007" for "2006".

2008. Act June 17, 2008, in subsec. (f), substituted "services furnished--" and paras. (1) and (2) for "services furnished after December 31, 2007".
Act Oct. 3, 2008 (effective on 1/1/2009, as provided by § 512(e) of such Act, which appears as a note to this section), deleted subsec. (f), which read:
"(f) Sunset. This section shall not apply to benefits for services furnished--
"(1) on or after January 1, 2008, and before the date of the enactment of the Heroes Earnings Assistance and Relief Tax Act of 2008, and
"(2) after December 31, 2008.[.]".
Act Oct. 3, 2008 (applicable with respect to group health plans for plan years beginning after the date that is 1 year after enactment, as provided by § 512(e) of such Act, which appears as a note to this section), substituted the section heading for one which read: "Parity in the application of certain limits to mental health benefits"; in subsec. (a), in para. (1), in the introductory matter, and, in subpara. (A), substituted "mental health or substance use disorder benefits" for "mental health benefits", in subpara. (B), in cl. (i), substituted "mental health and substance use disorder benefits" for "mental health benefits" in two places, and, in cl. (ii), substituted "mental health or substance use disorder benefits" for "mental health benefits", in subpara. (C), substituted "mental health and substance use disorder benefits" for "mental health benefits", in para. (2), in the introductory matter, and, in subpara. (A), substituted "mental health or substance use disorder benefits" for "mental health benefits", in subpara. (B), in cl. (i), substituted "mental health and substance use disorder benefits" for "mental health benefits" in two places, in cl. (ii), substituted "mental health or substance use disorder benefits" for "mental health benefits", and, in subpara. (C), substituted "mental health and substance use disorder benefits" for "mental health benefits", and added paras. (3)-(5); in subsec. (b), in para. (1), substituted "mental health or substance use disorder benefits" for "mental health benefits", substituted para. (2) for one which read: "(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits)."; in subsec. (c), in para. (1), inserted "(as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual)", substituted para. (2) for one which read: "(2) Increased cost exemption. This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent."; and, in subsec. (e), substituted paras. (4) and (5) for para. (4) which read: "(4) Mental health benefits. The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.".

2010. Act March 23, 2010, in subsecs. (a) and (b), substituted "or a health insurance issuer offering group or individual health insurance coverage" for "(or health insurance coverage offered in connection with such a plan)" wherever occurring; and in subsec. (c), in para. (1), substituted "and a health insurance issuer offering group or individual health insurance coverage" for "(and group health insurance coverage offered in connection with a group health plan)", and in para. (2)(A), substituted "or a health insurance issuer offering group or individual health insurance coverage" for "(or health insurance coverage offered in connection with such a plan)".

3. Redesignation:

This section, enacted as § 2705 of Part A of Title XXVII of Act July 1, 1944, ch 373, was redesignated § 2726 of such Part by Act March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(2), 124 Stat. 130.)

Section 1562 of Act March 23, 2010, P.L. 111-148, which amended this section, was redesignated § 1563 of such Act by § 10107(b)(1) of the Act.

4. Other provisions:

Applicability of section. Act Sept. 26, 1996, P.L. 104-204, Title VII, § 703(b), 110 Stat. 2950, provides: "The amendments made by this section [adding this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.".

Act Oct. 3, 2008; regulations. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(d), 122 Stat. 3891, provides: "Not later than 1 year after the date of enactment of this Act, the Secretaries of Labor, Health and Human Services, and the Treasury shall issue regulations to carry out the amendments made by subsections (a), (b), and (c) [amending 26 USCS § 9812, 29 USCS § 1185a, and 42 USCS § 300gg-5], respectively.".

Application of Oct. 3, 2008 amendments. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(e), 122 Stat. 3891; Dec. 23, 2008, P.L. 110-460, § 1, 122 Stat. 5123, provides:

"(1) In general. The amendments made by this section [for full classification, consult USCS Tables volumes] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of enactment of this Act, regardless of whether regulations have been issued to carry out such amendments by such effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5) [deleting 26 USCS § 9812(f), 29 USCS § 1185a(f), and 42 USCS § 300gg-5(f)], relating to striking of certain sunset provisions, shall take effect on January 1, 2009.

"(2) Special rule for collective bargaining agreements. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section [for full classification, consult USCS Tables volumes] shall not apply to plan years beginning before the later of--

"(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

"(B) January 1, 2010.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.".

Assuring coordination. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(f), 122 Stat. 3892, provides:

"The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may ensure, through the execution or revision of an interagency memorandum of understanding among such Secretaries, that--

"(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this section (and the amendments made by this section [for full classification, consult USCS Tables volumes]) are administered so as to have the same effect at all times; and

"(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.".

Notes:

Research Guide:

Law Review Articles:

Standard HIPAA Order in Civil Actions. 65 Ala Law 332. September 2004.

Stein. What Litigators Need to Know about HIPAA. 36 J Health L 433, Summer 2003.

Remus; L'Huillier. HIPAA and lawyers: yes, lawyers! 44 NH BJ 14, March 2003.

Langer. The HIPAA Privacy Rules: Disclosures of Protected Health Information in Legal Proceedings. 78 Wis L 14, April 2005.

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TOC: United States Code Service: Code. Const. Rules, Conventions & Public Laws > /.../ > EXCLUSION OF PLANS: ENFORCEMENT; PREEMPTION > **§ 300gg-26. Parity in mental health and substance use disorder benefits**
Citation: **42 U.S.C. 300gg-11**
Section: **42 USCS § 300gg-26**
View: Full
Date/Time: Tuesday, August 31, 2010 - 1:53 PM EDT

State Laws Mandating or Regulating Mental Health Benefits

Updated: February 2009; reposted with additions February 11, 2010. NEW

Mental health services have been one significant part of medical care for a number of years. However, the costs, coverage and availability of such services have been the object of policy discussions and a variety of state legislation. There is not a general consensus that state government should require coverage for mental health. 49 states and D.C. currently have some type of enacted law but these laws vary considerably and can be divided roughly into three categories:[1]

1. **mental health "parity" or equal coverage laws** [definition]
2. **minimum mandated mental health benefit laws** [definition]
3. **mental health "mandated offering laws".** [definition]

Note that some laws apply primarily to "serious mental illness" and may not assure coverage for particular individual diagnoses or circumstances. Many private market health plans include some type of mental health benefits on a voluntary commercial basis, not necessarily required by state or federal laws. Note that grief counseling may not be considered a covered benefit under some state laws, although it may be offered by insurers as part of a standard mental health benefit package. Laws in at least 38 states include coverage for substance abuse, alcohol or drug addiction.

CMS Guidance Regarding Mental Health Parity Requirements in CHIPRA, Medicaid and Group Insurance NEW

The federal Centers for Medicare & Medicaid Services (CMS) issued a State Health Official letter on November 4, 2009 regarding the mental health parity requirements under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The letter provides general guidance on implementation of section 502 of CHIPRA, Public Law 111-3, which imposes mental health and substance use disorder parity requirements on all Children's Health Insurance Program (CHIP) State plans under title XXI of the Social Security Act (the Act). This letter also provides preliminary guidance to the extent that mental health and substance use disorder parity requirements apply to State Medicaid programs under title XIX of the Act.

In summary the letter addresses specific requirements in the measure as follows:

1. Qualifying financial requirements and treatment limitations applied to mental health or substance use disorder benefits may be no more restrictive than those applied to medical surgical benefits.
2. No separate qualifying criteria may be applied to mental health or substance use disorder benefits.
3. When out-of-network coverage is available for medical surgical benefits, it must also be available for mental health or substance use disorder benefits.

Medicaid and Group Health Insurance:

Requirements from the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) became effective for group health insurance plans on October 3rd of 2009. These same requirements will only apply to Medicaid insofar as the state's Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs). In these cases the MCOs or PIHPs must be in compliance. A state Medicaid plan is not subject to these requirements otherwise. The MHPAEA applies to all CHIP programs and became effective April 1 of 2009. State CHIP plans are deemed in compliance if they provide coverage of Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefits.

States Requiring Legislative Action for Compliance

The letter also specifies that if a state requires legislation in order to be in compliance with the requirements, a state will not be found to be in violation before its next legislative session as long as it notifies the Secretary of HHS and she concurs that legislation is needed. They ask that states in the circumstances submit a letter to the Center for Medicaid and State Operations to that effect as soon as possible and include information as follows:

1. the provisions in question,
2. the reason the state requires legislative action for compliance, and
3. the date the state will begin implementing the provision.

Federal Law Requiring Parity in Some Circumstances - in effect 2010

On October 3, 2008, the Emergency Economic Stabilization Act (HR 1424) passed Congress and was signed into law. It included a major mental health provision - known as the "*Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*," which was attached to the economic bill and also became law. This federal mental health law requires health insurance plans that offer mental health coverage to provide the same financial and treatment coverage offered for other physical illnesses. It does not mandate that group plans must provide mental health coverage. [Parity Section 512 full text]

This legislation expands parity by requiring equality for deductibles, co-payments, out-of-pocket expenses, coinsurance, covered hospital days, and covered out-patient visits. The measure also includes a small business exemption for companies with fewer than 50 employees, as well as a cost exemption for all businesses if it will result in a cost increase of 2% in the first year and 1% in each subsequent year. The bill builds on the current 1996 federal parity law, which already requires parity coverage for annual and lifetime dollar limits. The current HIPAA preemption standard applies. This standard is extremely protective of state law. Only a state law that "prevents the application" of this Act will be preempted, which means that stronger state parity and other consumer protection laws remain in place. It will require the Comptroller General to inform Congress on health plans' and health insurers' coverage and exclusion rates, patterns, and trends of mental health and substance use disorder diagnoses. The new law exempts businesses with 50 or fewer employees from its mental health parity requirements.

Major provisions go into effect in 2010. Now that the federal government has released their long-awaited rules for complying with the Mental Health Parity Law (Fed. Register, Feb. 2), health plans and employers must act immediately to ensure compliance. Employers have until the first plan year beginning on or after July 1, 2010, to meet the requirements. With benefit design decisions needing to be made a few short months from now, health plans and sponsors need to take immediate steps to understand what is required and prepare for this major change in health insurance.

Sources: Press Release from the Office of U.S. Senator Pete Domenici; Press Release from the Office of U.S. Senator Edward Kennedy.
News Article: "Lawful Boost to Mental Health Coverage" Los Angeles Times, October 13, 2008.

Recent State Law History

In **2002** laws were added in **Alabama, Colorado, Kentucky, New Hampshire** and **New Jersey**.

In **2003**, "barebones" laws allowing exceptions to mandated coverage, were enacted in **Colorado, Montana and Texas. Maine** expanded categories of illnesses covered; **Hawaii** and **Kansas** extended dates of existing coverage laws.

In **2005**, **Washington** enacted a full mental health parity law, applying to health insurance, but exempting policies for individuals and small group employers with 50 or fewer employees. It will take effect in phases between 2006 and 2010. **Oregon** also enacted a full parity law that took effect January 1, 2007.

In **2006-07**, four additional states passed variations of full parity laws. **Idaho's** law provides parity, but only for state employee and family insurance policies. **New York's** former Gov. George Pataki signed Timothy's Law, named for a 12-year-old boy who committed suicide in 2001. The law requires that all private insurance policies have the same deductibles, number of office visits, number of inpatient visits and co-payments for mental health disorders as for other illnesses. The statute also requires that private plans provide at least 30 days of inpatient and 20 days of outpatient mental health care per year. In **Ohio**, outgoing Gov. Bob Taft signed his state's first mental health parity law (SB 116) on Dec. 29, 2006. The Mental Health Parity Act mandates that coverage provided for seven "biologically based mental illnesses," such as schizophrenia and bipolar disorder be on par with those for physical conditions. In July 2007 The **North Carolina** legislature enacted a measure covering nine conditions. See "TWO MORE STATES ENACT PARITY LAWS," State Health Notes, 1/22/07.

State Laws and Federal Limits: The state laws noted below generally do not apply to federally funded public programs such as Medicaid, Medicare, the Veterans Administration, etc. In addition, "self-funded" health insurance plans, often sponsored by the largest employers, usually are entirely exempt from state regulation because they are preempted by the federal ERISA law.

All of the state laws listed in this report were written and applied prior to the October 2008 passage of the Mental Health Parity and Addiction Equity Act, so coordination and interpretation of how state and federal laws combine or potentially conflict is a likely task for 2009.

> See ERISA and the States, a 2008 online resource guide by NCSL.

A Comment from the Commercial Sector

"Every client that I work with will have to make some plan-design changes to conform to the [new behavioral health parity provisions signed into law on Oct. 3]."

— Chip Kirby, an employee benefits attorney with Liberte Group LLC in Washington, D.C.,

told AIS's Health Plan Week., 10/24/2008

Mental Health Parity Laws
Parity, as it relates to mental health and substance abuse, prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. In short, parity requires insurers to provide the same level of benefits for mental illness, serious mental illness or substance abuse as for other physical disorders and diseases. These benefits include visit limits, deductibles, copayments, and lifetime and annual limits.
Parity laws contain many variables that affect the level of coverage required under the law. Some state parity laws--such as Arkansas'--provide broad coverage for all mental illnesses. Other state parity laws limit the coverage to a specific list of biologically based or serious mental illnesses. The state laws labeled full parity below provide equal benefits, to varying degrees, for the treatment of mental illness, serious mental illness and biologically based mental illness, and may include treatment for substance abuse. The newly enacted federal parity law affects insurance policies that already provide some mental health coverage; there is no federal law directly mandating parity to the same extent as state laws; also see background on unsuccessful federal parity legislation below the state table.

Minimum Mandated Benefit Laws
Many state laws require that some level of coverage be provided for mental illness, serious mental illness, substance abuse or a combination thereof. They are not considered full parity because they allow discrepancies in the level of benefits provided between mental illnesses and physical illnesses. These discrepancies can be in the form of different visit limits, copayments, deductibles, and annual and lifetime limits. Some mental health advocates believe these laws offer a compromise to full parity that at least provides some level of care. Others feel that anything other than full parity is discrimination against the mentally ill. Some of these laws specify that copayments and deductibles must be equal to those for physical illness up to the required level of benefits provided. If a law does not specify, the copayment could be as much as 50 percent of the cost of the visit and require a separate deductible to be met before mental health visits will be covered.

Mandated Offering Laws
Mandated offering laws differ from the other two types of laws in that they do not require (or mandate) benefits be provided at all. A mandated offering law can do two things. First, it can require that an option of coverage for mental illness, serious mental illness, substance abuse or a combination thereof, be provided to the insured. This option of coverage can be accepted or rejected and, if accepted, will usually require an additional or higher premium. Second, a mandated offering law can require that **if** benefits are offered **then** they must be equal.

Full Parity, Mandated Benefit and Mandated Offering State Laws

State	Eff. Date Law citation/ web link.	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit/	Co-pays and Co-insurance
AL	2001: H.677 of 2000	Individual and group with a small employer exemption of 50 or less.	Mental illness.	Mandated offering.	Must be equal.
AL	2002: S. 293	Adds health care service plans and health maintenance organizations (signed 4/26/02)	Mental illness	Mandated offering	Must be equal
AK	1997 ----- 2006 HB 289 ----- 2009 H 222 (Ch. 55 of 2009)	Group - 5 employees or less exempt; 20 or less must offer coverage. ------ Limited to large employer group markets, and does not apply if it would result in an increase in the cost of the plan of 1% or more. ----- Requires health care insurers in the group market to provide parity in the application of mental health and substance abuse benefits that comply with federal requirements	Alcoholism and Drug Use. ------ Mental Illness. ------ Mental health and substance abuse (effective 10/1/09)	Minimum Mandated ------- Mandated Benefit. ----- Mandated benefit	Must be equal ------ Must be equal.
AZ	1998: Ariz. Rev. Stat. Ann. 20-2322	Group with small employer exemption 50 or less, or cost increase of 1% or more.	Mental illness.	Mandate for plans that offer benefits.	Can be different.
AR	1987 ------ 1997: §23-00-506	Group and HMO. ------ Group: small employer exemption 50 or less; cost increase 1.5% or	Alcoholism and drug dependency. ------- Mental illnesses and	Mandated Offering ------ Full parity.	Not less favorable generally. ------ Must be equal.

	[Act 1020 of '97] --- 2001 HB 1562	more exempted. --- Not applicable to employers with 50 or fewer employees and to plans covering state employees. Exempts health benefit plans if it will result in cost increase of 1.5% or more.	developmental disorders. --- Mental Illness.	--- Minimum Mandated	--- Must be equal.
CA	1974: Cal. Ins. Code § 10125	Group.	Mental or nervous disorders.	Mandated offering.	Not specified.
CA	2000: Cal. Ins. Code § 10144.5	Group, individual and HMO.	Severe mental illness.	Full parity.	Must be equal.
CO	1992: Colo. Rev. Stat. § 10-16-104(5) --- 1994	Group. --- Group	Mental illness excluding autism. --- Alcoholism	Mandated benefits. --- Mandated Offering	Shall not exceed 50% of the payment. Deductible shall not differ. --- Shall not exceed 50% of the payment. Deductible shall not differ.
CO	1998: §10-16-104(5.5)	Group.	Biologically based mental illness.	Full parity.	Must be equal.
CO	2002: Chapter 208 of 2002	Provide coverage for substance abuse treatment regardless of whether the treatment is voluntary or court-ordered. (signed 5/28/02)	Substance abuse	Clarification of earlier laws	
CO	2003: H 1164	Allows exceptions for barebones policies		Exceptions	
CT	2000: Conn. Gen. Stat. §38a-488a; §38a-514a	Group and individual.	Mental or nervous conditions; alcoholism and drug addiction.	Full parity.	Must be equal.
DE	1999: Del. Code Ann. Tit. 18 § 3343 Tit. 18 § 3566 --- 2001 H 100	Group and individual. --- Group, HMO, individual and state employee plans.	Serious mental illnesses. --- Drug and Alcohol Dependencies.	Full parity. --- Parity	Must be equal. --- Must be equal.
FL	1992: Fla. Stat. § 627.668 --- 1993	Group and HMO. --- Group and HMO.	Mental and nervous disorders. --- Substance Abuse.	Mandated offering. --- Mandated offering.	May be different after minimum benefits are met. --- Not Specified.
GA	1998: Ga. Code §33-24-29; §33-24-28.1 (SB 620, 1998)	Group and individual.	Mental disorders including substance abuse.	Mandated offering.	Must be equal.
HI	1999: Hawaii Rev. Stat. §431M-5 --- 2000 HB 2392	Group and individual with small employer exemption- 25 or less employees. --- Deletes exemptions for employers with 25 or fewer employees & for government employee health benefit plans.	Serious mental illness. ---	Full parity. ---	Must be equal. ---

HI	1988: Hawaii Rev. Stat. §431M-1 ~7	Individual, group and HMO.	Mental illness.	Mandated benefits.	Must be comparable.
HI	2003: HB 1321 ------ 2005: SB 761	Makes law permanent, deleting sunset dates. ------ Expands definition of 'serious mental disorders' in current law to include delusional disorders, major depression, obsessive-compulsive disorders, and dissociative disorders.	Mental illness. --------	Full parity --------	 -------
ID	2006 HB 615 (ID Stat.: §67-5761A)	Health Insurance Plans for State Employees and their family members only.	Serious Mental Illness as defined in the APA's DSM-IV-TR.	Parity	Must be Equal.
IL	1991: Ill. Rev. Stat. Ch. 215 §5/370c ------ 1995 ----- 2001 SB 1341 ----- 2005 HB 59 ------- 2006 HB 4125	Group. ------ Group ------ Exempts employers with 50 or fewer employees. ------ Eliminates sunset provision in existing mental health parity law. ------ Makes HMOs subject to existing mental health coverage requirements.	Mental, emotional or nervous disorders. ------ Alcoholism ----- Serious Mental Illness ------ N/A ------- Increased number of visits for treatment of pervasive developmental disorders.	Full parity 2005 [See co-payment exceptions] Mandated offering, 1991-2004 ------- Mandated benefits ------ Parity for Serious mental illness; Mandated offering for other mental illness. ------ N/A ------- N/A	Insured may be required to pay up to 50% of the expenses incurred. ------- Not Specified. ------ Must be equal for serious illness. ------ N/A ------ N/A
IN	1997 HB 1400 ------ 2000: *H.1108 of '99*; Ind. Code § 27-13-7-14.8 Ind. Code § 5-10-8-9 (state)	Private Insurance Policies offering mental health benefits. Exempts employers with fewer than 50 employees and any business whose rates would increase over 1% as a result of legislation. ------ Group, individual and state employees with a small employer exemption 50 or less, or cost increase of 4% or more.	Mental Illness ------ Mental illness.	Parity ------- Mandate for plans that offer benefits. Full parity for state employee plans.	Not specified. ------ Must be equal for plans that offer coverage. Full parity for state employee plans.
IN	2003: H 1135	Adds substance abuse benefit for those with mental illnesses	Substance abuse	Mandate for those with mental illnesses	
IA	2005 HF 420; IA Code 514C.22 (2005)	Group policies to companies with more than 50 employees, public employees and small businesses that currently have mental health coverage.	Substance abuse, eating disorders, ADD not included.	Mandated Benefit.	Must be Equal.
KS	1998: § 40-2.105 2001: *H.2033 of '01* H 2071 of 2003 ------	Group, individual, HMO and state employee plans. H. 2071 extended sunset to Dec. 31, 2003.	Alcoholism or drug abuse or mental conditions.	Mandated benefits. ------	Not specified. ------

	2006 HB 2691	------ Group. If a policy does not have aggregate lifetime or annual limits on other medical benefits, then it may not impose them on mental health benefits.	------- Mental Illness	Minimum Mandated Benefits.	Not Specified.
KY	1980 ------ 1986: Ky. Rev. Stat. §§ 304.17-318 [group] §§304.38-193 [HMO]	Group ------ Group.	Alcoholism ------- Mental illness.	Mandated Offering. ------- Mandated offering.	Not Specified. ------ To the same extent as coverage for physical illness.
KY	2000: HB 268	Group with small employer exemption of 50 or less.	Mental illness and alcohol and other drug abuse.	Mandate for plans that offer benefits.	Equal if offered.
KY	2002: H 391 of '02	Small employer exemption raised to 51.			
LA	2000: La. Rev. Stat. Ann. § 22:669(1)	Group, HMO and state employee benefit plans.	Serious mental illness.	Mandated benefits.	Must be equal.
LA	1982: § 22:669(2)	Group, self-insured and state employee plans.	Mental illness.	Mandated offering.	Must be equal.
LA	1982: §22:215.5	Group.	Alcoholism and drug abuse.	Mandated offering.	Not specified.
ME	1984 ------ 1996: Me. Rev. Stat. Tit. 24 § 2325-A	Group with a small employer exemption for 20 employees or less. ------ Group with a small employer exemption for 20 or less.	Alcoholism and drug dependency. ------ Mental illness.	Mandated Benefit. ------ Full parity.	May place a maximum limit on benefits as long as they are consistent with the law. ----- Must be equal.
ME	1996: Me. Rev. Stat. tit. 24 § 2325-A(5-D)	Individual plans must offer coverage.	Mental illness.	Mandated offering.	Must be equal.
ME	2003: H 973	Group of 21 or more, including HMOs, adds substance abuse-related disorders and other illness categories.	Substance abuse, etc.	Full parity	
MD	1994: Md. Ins. Code Ann. § 15-802 (click 'code folder', then 'insurance', title 15, section 802)	Individual and group.	Mental illness, emotional disorder, drug abuse or alcohol abuse disorder.	Full parity [See co-payment exceptions]	Must be equal. Except outpatient: 80% -visits 1-5; 65% - visits 6-30; 50% visits over 30.
MD	2002: Chapter 394 of '02 (eff. 10/1/02)	Requires individual and group insurers, nonprofit health service plans, and HMOs to provide coverage for medically necessary residential crisis services.	Residential crisis services		
MA	1991 ------ 1996: Mass. Gen. Laws Ch. 175:47B	Individual, group, HMO. ------ Individual, group and HMO.	Alcoholism. ------ Mental or nervous conditions.	Mandated Benefits. ------ Mandated benefits.	Not specified. ------ Not specified.
MA	2001: *S.2036/ Ch. 80 of '00*	Individual, group and HMO. [Pro and Con testimony on costs of expansion]	Biologically-based mental illness.	Full Parity for bio -based; mandated benefits of mental illness and substance abuse.	Must be equal.

MI	1988 --- 2001: *S.1209 of '00, see §3501*	Group for Inpatient; Group and Individual for other levels. Exemption for cost increases of 3% or more. --- HMO's only, group and individual contracts, with a cost exemption of 3%.	Mental health and substance abuse --- Mental health and substance abuse	Minimum mandated benefits. --- Minimum mandated benefits.	Charges, conditions for services shall not be less favorable than the maximum for any other comparable service. --- Charges, conditions for services shall not be less favorable than the maximum for any other comparable service.
MN	1986 --- 1995; 2000: Minn. Stat. § 62A.152	Group and Individual. --- Group, individual and HMO's (full parity for HMO's).	Alcoholism, chemical dependency, or drug addiction. --- Mental health and chemical dependency.	Mandated Benefit. --- Full parity for plans that offer coverage and HMO's.	Not Specified. --- Must be equal.
MS	1975: Miss. Code Ann. § 83-9-39 to 41	Group.	Alcoholism.	Mandated benefit.	Not specified.
MS	2002: Miss. Code Ann. § 83-9-41; H667 of '01	Group and individual with an exemption if costs of implementation are 1% or more of overall costs.	Mental illness.	Mandated offering for small employers of 100 or less. Minimum mandated benefits for others.	Must be equal for inpatient and partial, however, payment for outpatient visits shall be a minimum of fifty percent (50%) of covered expenses.
MO	1997: §§ 376.825; § 376.811	Group, individual and HMO.	Mental disorders and chemical dependency.	Mandated offering.	Must be equal.
MO	2000: § 376.825 *H.191 of '99* --- *2004*	Group and individual. --- Group	Mental illness including alcohol and drug abuse. --- Mental Illness	Mandate for plans that offer benefits. --- Parity	Shall not be unreason-able in relation to the cost of services provided for mental illness. --- Must be equal.
MT	2000: Mont. Code Ann. § 33-22-706	Group and individual.	Severe mental illness.	Full parity.	Must be equal.
MT	1997; 2001 Mont. Code Ann. § 33-22-701 to 705	Group.	Mental illness alcoholism and drug addiction.	Mandated benefits.	No less favorable up to maximums.
MT	2003: H 384	12 month pilot allows exceptions for barebones policies.		Exceptions	
NE	1989 --- 2000:	Group and HMO --- Group and HMO with a small employer exemption of 15 or less.	Alcoholism --- Serious mental illness.	Mandated Offering. --- Mandate for	No less favorable generally than for physical illness. --- May be different.

	§§ 44-791 to 44-795			plans that offer coverage.	
NV	1997 ------- 2000: Nev. Rev. Stat. §§ 689A.0455; 689B.0359; 695B.1938; 695C.1738	Group, individual, and HMO. ------ Group and individual with a small employer exemption 25 or less, or cost increases of 2% or more.	Abuse of alcohol or drugs. ------- Severe mental illness.	Mandated benefits. ------- Mandated benefits.	Must be paid in the same manner. ------- Not more than 150% of out-of-pocket expenses required for medical and surgical.
NH	1993: N.H. Rev. Stat. Ann. §§ 415:18-a	Group, individual and HMO. Specifies different benefits for mental illness under major medical and non-major medical plans.	Mental or nervous conditions.	Mandated benefits.	Ratio of benefits shall be substantially the same as benefits for other illnesses.
NH	1995: § 417:E-1	Group.	Biologically- based mental illnesses	Full parity.	Must be equal.
NH	2002: H 762; Chapter 204 of 2002	Any policy of group or blanket accident or health insurance.	Parity for bio-based illnesses, mandated benefits for other MI's and substance abuse		
NJ	1985 ------ 1999: §§ 17:48-6v; 17-48A-7u; 17B:26-2.1s ------- 2000 ------ 2002	Group and individual. ------ Group and individual ------ State Employee Plans. ------ Individual Health Plans.	Alcoholism ------- Biologically based mental illness. ------- Biologically based mental illness. ------ Biologically based mental illness; alcohol and substance abuse.	Mandated benefits for care prescribed by a doctor. ------ Full parity. ------ Parity. ------ Mandated Offering.	Must be equal. ------ Must be equal. ------ Must be equal. ------ Bio based mental illness: No coinsurance but $500 copayment per inpatient stay. 30% coinsurance for outpatient stay. Alcohol and substance abuse: 30% coinsurance.
NM	1987 ----- 2000: N.M. Stat. Ann. §59A-23E-18	Group. ----- Group with different exemptions for small and large employers.	Alcoholism ----- Mental health benefits.	Mandated Offering. ----- Full parity.	Consistent with those imposed on other benefits. ----- Must be equal.
NY	1998: Ins. Law § 3221 (1)(5)(A) ---------- 2004 --------- 2006	Group. -------- Group ------- All private insurance policies. See: Timothy's Law web site, 2007.	Mental, nervous, or emotional disorders and alcoholism and substance abuse. ------- Eating Disorders -------- Mental health disorders	Mandated Offering. -------- Minimum Mandated Benefit. -------- Full parity	As deemed appropriate and are consistent with those for other benefits ------- Not Specified. ------- Must be equal. State to foot the

					bill for additional costs incurred by businesses with fewer than 50 employees; the Legislature allocated some $50 million to cover those costs
NC	1985 --- 1991 HB 279 --- 1997: N.C. Gen. Stat. § 58-51-55 --- 2007	Group --- State Employees Health Plan. --- State Employees Health Plan --- Health Insurers	Chemical Dependency. --- Mental Illness --- Mental illness and chemical dependency. --- Mental Illness	Mandated Offering. --- Parity --- Full parity. --- Parity	$8,000 per year and $16,000 per lifetime. --- Must be equal --- Must be equal. --- Must be equal.
ND	1995: N.D. Cent. Code § 26.1-36-09 *[page 431]*	Group and HMO.	Mental disorders, alcoholism and drug addiction.	Mandated benefits.	No deductible or copay for first 5 hours not to exceed 20% for remaining hours.
ND	2003: H 2210	Adds that inpatient treatment and partial hospitalization, or alternative treatment must be provided by an addiction treatment program licensed under chapter 50-31.	Substance abuse	Clarification	
OH	2006: SB 116 --- 1985: Ohio Rev. Code Ann.§ 3923.30	Law signed 12/29/06; effective --- Group and self-insured.	7 "biologically based mental illnesses," such as schizophrenia and bipolar disorder --- Mental or nervous disorders and alcoholism.	Full Parity --- Mandate for plans that offer mental health coverage. Mandated benefits for alcoholism.	--- Subject to reasonable deductibles and coinsurance.
OK	2000: Okla. Stat. tit. 36 §6060.11 to §6060.12 (SB 2, 1999)	Group with a small employer exemption 50 or less, or cost increase of 2% or more.	Severe mental illness.	Full parity.	Must be equal.
OR	1981 --- 2000: Or. Rev. Stat § 743.556 --- 2005: SB 913	Individual --- Group and HMO. --- Group.	Alcoholism --- Mental or nervous conditions including alcoholism and chemical dependency. --- Mental, nervous conditions including alcoholism and chemical dependency.	Mandated Offering. --- Mandated benefits. --- 2007: Full parity NEW	Coverage must be no less than 80% of total. --- Shall be no greater than those for other illnesses. ---
PA	1989	Group and HMO.	Alcoholism or drug addiction.	Mandated benefits.	For the first course of treatment shall be no greater

	------ 1999 H.366 of 1998. (see § 634)	------ Group and HMO-small employer exemption 50 or less.	------ Serious mental illness.	------ Mandated benefits.	than those for other illnesses. ------ Must not prohibit access to care.
RI	1995 ----- 1995 R.I. Gen. Laws § 27-38-2.1	Individual, group, self-insured and HMO. ----- Individual, group, self-insured and HMO. *(in effect through 12/31/2001)*	Substance dependency and abuse. ------ Serious mental illness.	Mandated benefits. ------ Full parity.	Not Specified. ----- Must be equal.
RI	1/1/2002 H.5478/ S.832 of 2001	Expands the state mental health parity law to include coverage for all mental illnesses and substance abuse disorders. *(replaces § 27-38.2-1 above)*	All mental illnesses & substance abuse disorders.	Full parity	Must be equal
SC	1994 S.C. Code Ann. § 38-71-737	Group.	Psychiatric conditions, including substance abuse.	Mandated offering.	May be different.
SC	2000 SB 1041 (repealed Jan 1, 2005) ------ 2005 SB 49	State employee insurance plan with cost increase exemptions. ------ Health Plan Insurers. Individual and small group policies are exempt.	Mental health condition or alcohol or substance abuse. ------ Psychiatric illnesses as defined by DSM-IV published by the APA.	Full parity. ------ Parity.	Must be equal. ------ Must be equal.
SD	1979 ------ 1998 § 58-17-98 (HB 1262, 1998) ------ 1999 HB 1264 ------ 2003 HB 1236	Group, individual and HMO. ------ Group, individual and HMO. ------ Group, individual and HMO. ------ Group, individual and HMO.	Alcoholism. ------- Biologically- based mental illness. ------- Clarifies biologically based mental illness as: schizophrenia, other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder. ------- Offers exclusion of coverage for specified mental illness.	Mandated Offering. ------- Full parity. ------- Parity ------- n/a	Must be equal. ------- Must be equal. ------ Must be equal. ------ n/a
TN	1982 ------ 2000 § 56-7-2360; § 56-7-2601	Groups with exemptions for employers with 50 or fewer employees or it plan results in cost increases of 1% or more. ------ Group with a small employer exemption 25 or less, or cost increase of 1% or more.	Alcohol and Drug Dependency. ------ Mental or nervous conditions.	Mandated Offering. ------ Mandated benefits.	Must be equal. ------ Must be equal.
TX	1981 ------ 1991	Group and self-insured with an exemption for self-insured plans of 250 or less. ----- State employee plans.	Chemical Dependency. ------	Mandated Benefit. ------ Full parity.	Must be sufficient to provide appropriate care. ------ Must be equal.

TX	1997 Ins. art. 3.51-14	Group and HMO, with a small employer exemption of 50 or less.	Biologically-based mental illness. Serious mental illness.	Mandated benefits with a mandated offering for small groups of 50 or less.	Must be equal.
TX	2003: SB 541	Allows insurers and HMOs to offer policies without mandates for the treatment of mental illness and chemical dependency, with an exception for serious mental illnesses.		Exceptions	
UT	2001 Utah Code Ann. 31A-22-625 (HB 35, 2000)	Group (as of 7/1/01) and HMO's (as of 1/1/01)	Mental illness as defined by the DSM.	Mandated offering.	May include a restriction.
VT	1997 Vt. Stat. Ann. tit. 8 §4089b (HB 57, 1997) ------- 2006 HB 40.	Group and individual. ------- Amends the 1998 statute to add an "any willing provider" amendment. The law prohibits an insurer from excluding from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer.	Mental health condition including alcohol and substance abuse. --------	Full parity. --------	Must be equal. --------
VA	2000 thru 7/1/2004 & indefinitely. Va. Code. § 38.2-3412.1	Group and individual with a small group exemption 25 or less. (Note: Extended without sunset date by S 44, see below)	Biologically-based mental illness including drug and alcohol addiction.	Full parity.	Must be equal to achieve the same outcome as treatment for any other illness.
VA	Effective 7/1/2004. § 38.2-3412.1	Group, individual and HMO. (See 2004 change, below)	Mental health and substance abuse.	Mandated benefits.	Co-insurance for outpatient can be no more than 50% after 5th visit. All others must be equal.
VA	S 44 of '04	Repeals sunset date of 7/1/04, above. (enacted 3/19/04)	Mental health and substance abuse.		
VA	S 212 of '04 *§§ 37.1-255*	Establishes Inspector General for Mental Health	Mental health & substance abuse		
WA	1987 Wash. Rev. Code § 48.21.241 -------- 2005 HB 1154 (effective 2006-10) --------	Group and HMO. ------- State's Basic Health Plan and businesses with 51 or more employees, excluding those that are self-insured. ------ Clarifies that mental health	Mental health treatment. ------ Mental Health Services except substance related disorders, life transition problems, skilled nursing services, home health care, or court ordered treatment. Court ordered treatment	Mandated offering. ------ Mandated offering. ---------	Reasonable deductible amounts and co-payments. ----- Not Specified. ---------

	2006 HB 2501	coverage applies to all group health plans for groups other than small groups as defined in existing state law. Provides that the copayment or coinsurance for mental health services be no more than the co-payment or coinsurance for medical and surgical services otherwise provided under the health benefit plan.	allowed if deemed medically necessary. ------- Requires prescription drugs to treat mental illness be covered as are other prescription drugs.		
WV	1998 § 33-16-3a	Group and individual with a cost increase exemption of 1%.	Mental or nervous conditions.	Mandated offering.	Not specified.
WV	2002 HB 4039 ------ 2004 HB 4286	Insurance plans and HMOs. Law allows insurer to apply "whatever cost containment measures may be necessary" to maintain costs below 2% of the total costs for the plan. ------- Repeals a section in previous statute relating to coverage for alcohol dependency since it is superseded by a section that explicitly mentions substance abuse treatment.	Serious Mental Illness as defined in the APA DSM. ---------	Full parity ----------	Not specified. ---------
WI	Wis. Stat. § 632.89 ------ 2004 SB 71	Group (with "at least specified minimum benefits in every group contract") ------ Group Insurance	Mental or nervous disorders ------ Exempts prescription drugs and diagnostic tests from minimum coverage limits.	Mandated offering ----- Mandated Offering.	Comparable deductibles and copays ------ Not specified.
D.C.	D.C. Code §31-3102			Mandated mental health coverage; specified minimum benefits	

NOTES for state mental health statute table:
A) The *Diagnostic and Statistics Manual of the American Psychiatric Association* (DSM) includes universally accepted definitions and descriptions of mental illnesses and conditions. There are 13 DSM diagnoses commonly referred to as biologically-based mental illnesses by mental health providers and consumer organizations. Between 3 and 13 of these diagnoses are referred to in various state parity laws. For example, in Alabama, mental illness is defined as: 1) schizophrenia, schizophrenia form disorder, schizo-affective disorder; 2) bipolar disorder; 3) panic disorder; 4) obsessive-compulsive disorder; 5) major depressive disorder; 6) anxiety disorders; 7) mood disorders; 8) Any condition or disorder involving mental illness, excluding alcohol and substance abuse, that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Disease, as periodically revised.

B) **NAIC Mental Illness Treatment tally.** The National Association of Insurance Commissioners lists 46 states with mandated requirements, not mentioning AK, AZ, MI and WY, as of February 2008.

C) Examples of "Barebones" exception laws:

Colorado H 1164
Texas S 541 of 2003
Montana H 384of 2003

of 2003 allows small employers to purchase a basic health benefit plan that does not include mental health and substance abuse treatment mandates. allows insurers and HMOs to offer policies without mandates for the treatment of mental illness and chemical dependency, with an exception for serious mental illnesses if the plan is issued to a large employer. An insurer that offers such policy must also offer at least one policy with state-mandated health benefits. allows for a 12-month demonstration project that in some cases, permits a limited coverage plan or managed care plan without mandates for mental illness

Federal Parity Amendment
In 1996 a federal parity amendment was signed into law as part of the VA-HUD appropriations bill. The law, otherwise

known as the Mental Health Parity Act of 1996 (Public Law 104-204, see text online), prohibits group health plans that offer mental health benefits from imposing more restrictive annual or lifetime limits on spending for mental illness than are imposed on coverage of physical illnesses. This law expired on September 30, 2001 due to a "sunset" provision, but was extended through December 31, 2002 when President Bush signed Public Law 107-116. The Mental Health Parity Act of 1996 offers limited parity for the treatment of mental health disorders. The statute does not require insurers to offer mental health benefits, but states that if mental health coverage is offered, the benefits must be equal to the annual or lifetime limits offered for physical health care. It also does not apply to substance use disorders, and businesses with fewer than 26 employees are exempt..

On October 30, 2001 the U.S. Senate passed a broader parity bill, which was sent to the House. On December 18, in a House-Senate negotiating meeting, the House members rejected the Senate bill by a 10n-7y vote. The *New York Times* reported that sponsors Senators Domenici and Wellstone "said they wanted to requires health plans and insurance companies to provide equivalent coverage, or parity for mental and physical illness. House Republicans, employers and insurance companies objected to the proposal, saying it would increase costs for employers in a recession, when many businesses are already cutting health benefits because of a resurgence in medical inflation."[6]

9-11: Terrorism Impacts on Mental Health

The events of September 11, 2001 and related bio-terrorism scares had a profound effect on Americans in every part of the United States. In 2003, the war with Iraq brought the potential for new psychological and mental health concerns, according to the American Psychological Association. Yet the issues raised have been a part of health policy for more than two decades.

The nation, through the actions of federal, state and local governments, and citizens in innumerable roles, united and moved forward. However, the medical traumatic effects of those events impacted many people, for months or even years. *USA Today* reported it this way: "The terrorist strikes and their devastating aftermath are triggering the largest mental health challenge ever faced by employers and straining the USA's army of grief counselors, not just at the attack sites but in workplaces across the country. The emotional fallout was expected to be so widespread that some health insurers are loosening restrictions on employees' use of mental health services." [1] The impact could be far larger than the numbers directly affected. For example, just in Arlington County, Virginia, "some 20,000 to 40,000 of the county's 200,000 residents could experience a traumatic stress reaction from the attacks, officials estimate, pointing to an earlier Surgeon General's report on mental health and disasters." [2]

Mental Health Benefits and Hurricane Katrina Victims

The widespread harm inflicted by Hurricane Katrina includes health impacts and longer-term mental and emotional harm. People who are displaced, injured, have lost loved ones, homes, property, belongings, jobs, family stability, pets, and those with friends, relatives or coworkers affected, may need or seek counseling and medical help. Some, but not all, of the varying state health insurance mandate laws may require coverage of either emergency or longer-term mental health services.

The list below is a general survey of these laws. It provides a quick comparison among states, but it is not intended as a consumer guide to services, since coverage varies even further based on employer and individual contracts, including services offered above or beyond the minimum required by state law. Also public programs including Medicaid, Medicare, local health departments have separate standards of coverage - sometimes more extensive -- than private market health policies.

Expert Sources and Reports

1. U.S. General Accounting Office, *"Mental Health Parity Act: Despite Federal Standards, Mental Health Benefits Remain Limited"* GAO/HEHS-00-95 (Washington, D.C., May 2000) [includes state charts]
2. U.S. General Accounting Office, "*Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161 (Washington, D.C: August 1996).
3. U.S. Department of Health and Human Services, Public Health Service, "The Costs and Effects of Parity for Mental Health" (Merrille Sing, Mathematica, 2001)
4. National Center for Policy Analysis, *An Easy Way to Make Health Insurance More Expensive,* February 21, 1997. (Obtained from http://www.ncpa.org/pub/ba/pdf/ba224.pdf; Internet.)
5. Gail A. Jensen and Dr. Michael A. Morrisey, *Mandated Benefit Laws and Employer- Sponsored Health Insurance,* (Health Insurance Association of America: January 1999).
6. "*Drive for More Mental Health Coverage Fails in Congress*", New York Times, December 18, 2001.

For related news stories and resources see:

"Hurricane Katrina Survivors Lack Access to Mental Health Services" The majority of Hurricane Katrina survivors who developed mental disorders after the disaster are not receiving the mental health services they need, and many who were receiving mental health care prior to the hurricane were not able to continue with treatment, according to an NIMH-funded study published online in the American Journal of Psychiatry. National Institutes of Health (NIH) 12/17/07.

"TWO MORE STATES ENACT PARITY LAWS," State Health Notes, 1/22/07

Resilience in the Time of War - articles by American Psychological Association (APA) including tips for assisting children and adults. - March 2003.

Communities Gear Up for Long-Term Effects of Disaster - Health Intelligence Network- October 8, 2001 [2]

Psychiatric Dimensions of Disaster a resource list by The American Psychiatric Association, Sept. 2001

Resources for Responding to Trauma and Terrorism - web page by the National Assoc. Mental Illness

Disaster Mental Health: Dealing with the Aftereffects of Terrorism - resources from the National Center for Post Traumatic Stress Disorder (PTSD)

What are the Traumatic Stress Effects of Terrorism? - fact sheet from NCPTSD, September 2001

Recommendations for Pharmaceutical Treatment of Acute Stress Reactions - Sept. 26. 2001

HHS Makes $35 M in Emergency Funds Available to Entities that Suffered Losses from September Attacks - competitive grants for public and not-for-profit health entities. These grants target NY, CT, NJ, VA, PA and D.C. - news release October 9, 2001

Nation in shock seeks counseling, consoling - USA Today, September 20, 2001 [1]

Public Health Preparedness - web updates from CDC, August 2002

Mental Health menu page - NCSL resources, updated regularly, 2004

Mental Health Parity: A State Lawmaker's Digest, NCSL, 2001

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NFIB

The Voice of Small Business®

ALASKA

SB 52

February 28, 2011

The Honorable Bettye Davis
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 52

Dear Senator Davis,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 52. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately, SB 52 mandates specified coverage of mental health, alcoholism and substance abuse that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices

to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

Estimates from the *Health Insurance Mandates in the States 2010* by the Council for Affordable Health Insurance, suggest that this mandate will increase premium by 5% t0 10%. With such a premium increase, clearly many small businesses will be forced to drop health insurance coverage for their employees.

SB 52 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs. Thus it creates a less fair business environment for small employers.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director