MANDATED BENEFIT REVIEW OF HOUSE BILL 2065
SUBMITTED TO THE 192ND GENERAL COURT:

AN ACT TO UPDATE MENTAL HEALTH PARITY

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1.0 Benefit Mandate Overview: H.B. 2065: An Act to Update Mental Health Parity

1.1 History of the Bill

The Massachusetts Legislature's Committee on Mental Health, Substance Use and Recovery referred House Bill (H.B.) 2065, entitled, "An Act to Update Mental Health Parity,"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. Massachusetts General Law (MGL) Chapter 3 §38C requires CHIA to review the medical efficacy of treatments or services included in each mandated benefit bill referred to the agency by a legislative committee, should it become law. CHIA must also estimate each bill's fiscal impact, including changes to premiums and administrative expenses.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of Commonwealth of Massachusetts (Commonwealth) defrayal under the Affordable Care Act (ACA), nor is it intended to assist with Commonwealth defrayal calculations if it is determined to be a health insurance mandate requiring Commonwealth defrayal.

1.2 What Does the Bill Propose?

As submitted to the 192nd General Court of the Commonwealth, the bill requires insurers to cover any medically necessary treatment for any mental health condition, including autism spectrum disorder, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)[2] or the most current version of the International Classification of Diseases (ICD)[3] on a nondiscriminatory basis to all residents of the Commonwealth. In addition, the bill removes language requiring coverage on a nondiscriminatory basis for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, whenever the costs of diagnosis and treatment exceed the maximum compensation permitted to such victims by statute. [4]

1.3 Medical Efficacy of the Bill

The bill adopts a broad definition of mental health and substance use disorder (MH/SUD) diagnoses requiring nondiscriminatory coverage and strikes the "biologically-based" description that was used to define mandated coverage in the first Massachusetts mental health parity law passed in 2000. If the bill were to pass, it would codify at the state level requirements of federal mental health parity laws and regulations. The bill does not add MH/SUD coverage beyond what the carriers report or additional parity requirements. Bill passage might bring a heightened awareness to the mental health parity topic; however, no direct efficacious impact has been identified.

All respondent carriers already cover rape and rape-related mental or emotional disorder services, without regard to whether the member receives the maximum compensation awarded to such victims permitted by statute.[5] Services related to rape and rape-related mental or emotional disorders are covered the same as other MH/SUD services. If the bill were to pass, coverage by the carriers for these services would not change, and therefore, would not be expected to impact the health of the population affected by the bill.

1.4 Current Coverage

Massachusetts state law currently mandates that fully-insured plans, fully-insured employer-sponsored plans, individual plans, and state employee plans provide behavioral health treatment services on a nondiscriminatory basis for a select list of "biologically-based" diagnoses. These conditions include: schizophrenia, schizoaffective disorder, major depressive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism.[6] The law requires that annual limits, lifetime limits, and quantitative treatment limits for these conditions are equal to those for other medical conditions. Coverage of treatment for patients with conditions not on the specified list is also required in the form of a minimum-60-day inpatient treatment, and 24 outpatient visits if the treatment is deemed medically necessary. [7] Insurance plans must also provide coverage for children under age 19 who do not have a condition on the specified list but who cannot attend school because of a behavioral condition, or are hospitalized due to a condition, or possess behavior that could endanger themselves or others.

Under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), group health plans and health insurance carriers that offer MH/SUD benefits may not impose more stringent benefit limits on those benefits than on medical/surgical benefits. Mental health services are considered one of the 10 essential health benefits (EHBs) under the Affordable Care Act (ACA). Benefits are defined for Massachusetts according to its benchmark plan (the Blue Cross and Blue Shield of Massachusetts [BCBSMA] HMO Blue plan). The Commonwealth's benchmark plan provides coverage for behavioral health benefits required to be covered under the ACA and MHPAEA.

BerryDunn surveyed nine insurance carriers in the Commonwealth, and six carriers responded. All of the respondent insurance carriers reported covering medically necessary MH/SUD services for diagnoses as defined in the most recent DSM or most current version of the ICD. Furthermore, all respondent carriers reported providing coverage on a nondiscriminatory basis for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape.

1.5 Cost of Implementing the Bill

The bill does not expand on federal mental health parity law requirements, and carriers currently cover all MH/SUD benefits described in the bill. Carriers currently cover rape-related mental or emotional disorders the same as other MH/SUD services. Therefore, if the bill were to pass, the cost would be immaterial and assumed to be zero.

1.6 Plans Affected by the Proposed Benefit Mandate

The bill amends statutes that regulate healthcare carriers in the Commonwealth. It includes the following sections, each of which addresses statutes regarding a particular type of health insurance policy when issued or renewed in the Commonwealth:

Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees

Chapter 175 – Commercial Health Insurance Companies

Chapter 176A – Hospital Service Corporations

Chapter 176B – Medical Service Corporations

Chapter 176G – Health Maintenance Organizations (HMOs)

1.7 Plans Not Affected by the Proposed Benefit Mandate

Self-insured plans (i.e. where the employer or policyholder retains the risk for medical expenses and uses a third-party administrator or insurer to provide only administrative functions), except for those provided by the Government Insurance Commission (GIC), are not subject to state-level health insurance mandates. State mandates do not apply to Medicare and Medicare Advantage plans or other federally-funded plans, including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employees Health Benefit Plan, the benefits for which are determined by, or under the rules set by, the federal government.

Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 2065, "An Act to Update Mental Health Parity." Accessed April 8, 2022: **https://malegislature.gov/Bills/192/H2065**.

[2] The Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition, Text Revision (DSM-5-TR), is the most current DSM available.

[3] ICD-10 was implemented on October 1, 2015. See **https://www.cms.gov/Medicare/Coding/ICD10**.

[4] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 2065, "An Act to Update Mental Health Parity." Accessed April 8, 2022: **https://malegislature.gov/Bills/192/H2065**.

[5] Maximum awards; compensable expenses. MGL 258C Section 3. Accessed 2022 June 6: **General Law - Part III, Title IV, Chapter 258C, Section 3 (malegislature.gov)**.

[6] Mental Health Parity. Mass Legal Help. Accessed May 10, 2022. **https://www.masslegalhelp.org/mental-health/mental-health-parity**.

[7] Diagnoses include: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism. Mass. General Laws c.175 § 47B. Accessed February 2, 2022. **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47B**.

2.0 Medical Efficacy Assessment

As submitted to the 192nd General Court of the Commonwealth, the bill requires health insurance coverage on a nondiscriminatory basis for the diagnosis and medically necessary treatment for any mental health condition, including autism spectrum disorder, as described in the most recent edition of the DSM or the most current version of the ICD, to all residents of the Commonwealth.[1] The bill strikes the current "biologically-based" description of covered MH/SUD diagnoses as well as a provision requiring nondiscriminatory coverage for additional diagnoses in the most current DSM upon approval by the commissioner of health. In addition, the bill removes language requiring coverage on a nondiscriminatory basis for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, whenever the costs of diagnosis and treatment exceed the maximum compensation permitted by statute.[2]

BerryDunn consultants solicited information from the sponsoring legislator when interpreting the bill's intent. The sponsoring legislator indicated the bill's intent is to codify federal mental health parity requirements into state law. Furthermore, the bill's intent is to strike the current "biologically-based" description of covered MH/SUD diagnoses.

MGL Chapter 3 §38C charges CHIA with reviewing the medical efficacy of proposed mandated health insurance benefits. Medical efficacy reviews summarize current literature on the effectiveness and use of the treatment or service and describe the potential impact of a mandated benefit on the quality of patient care and health status of the population.

This report proceeds in the following sections:

2.1 Introduction

Mental health is necessary for overall health and wellbeing.[3] According to the U.S. Census Bureau Household Pulse Survey, almost one third (31.4%) of Massachusetts adults age 18 and older reported symptoms of anxiety and/or depressive disorder from September 29 to October 11, 2021.[4] This is an increase from 2018-2019, when 21.1% of adults in Massachusetts reported having any mental illness.[5]

Deaths attributable to drug overdoses have increased in Massachusetts from 28.0 per 100,000 in 2015 to 33.6 per 100,000 in 2020.[6] One of the primary drivers of the increase in deaths due to drug overdose is opioid usage. In 2020, the majority (89.8%) of all drug overdose deaths in the state was due to opioid overdose deaths (2,062).[7] This trend has been increasing in MA, as the age-adjusted death rate due to opioid overdose almost tripled from 2009 to 2019;

9.4 per 100,000 to 28.9 per 100,000.[8] Alcohol use disorder was also present prior to the pandemic, with 1.8% of adolescents and 6.5% of adults in Massachusetts reporting having alcohol use disorder during 2018 to 2019.[9] Among adolescents, 3.3% reported having an illicit drug use disorder, and among adults, 3.4% reported having an illicit drug use disorder from 2018 to 2019.[10]

Individuals with MH/SUD conditions have historically faced stigma, discrimination, and other barriers inside and outside the health care system.[11,12] Mental health parity legislation is intended to bring MH/SUD care in alignment with medical/surgical care and provide equal access for MH/SUD care.

2.2 Brief History of Federal and State Mental Health Parity Legislation

In 1996, Congress passed the Mental Health Parity Act (MHPA), which prohibited carriers from imposing annual and lifetime dollar limits on mental health that were more restrictive than the limits on medical/surgical benefits in large employer-sponsored group health plans.[13] This federal legislation applied to plan years beginning on or after January 1, 1998. MHPA did not require coverage of mental health diagnoses; rather, it required parity of coverage if the plan offered mental health services. Furthermore, the federal law did not require parity for substance use disorder (SUD) benefits.

In 2000, Massachusetts passed a parity law, "An Act Relative to Mental Health Benefits" that went further than the existing federal legislation by requiring coverage of the following "biologically-based" mental health diagnoses:[14]

- Schizophrenia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Paranoia and other psychotic disorders
- Obsessive-compulsive disorder
- Panic disorder
- Delirium and dementia
- Affective disorder
- Any other "biologically-based" mental disorders appearing in the most recent edition of the DSM that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of the Division of Insurance.

The law was amended in 2008 to include the following diagnoses (effective July 1, 2009):

- Eating disorders
- Post-traumatic stress disorder
- Substance abuse [use] disorders

- Autism

In addition, the law added the provision to require coverage of rape-related mental or emotional disorders in cases when the cost of diagnosis and treatment is greater than the maximum compensation given to victims in accordance with Massachusetts law.[15] The bill would strike this provision and the "biologically-based" description above.

The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded MHPA and also required parity of SUD benefits if provided by a plan.[16] MHPAEA requires coverage for MH/SUD services to be no more restrictive than coverage for medical/surgical services. Federal law did not require plans to cover MH/SUD benefits until the ACA; prior to this time, federal law required parity between MH/SUD and medical/surgical benefits if the carrier chose to cover MH/SUD benefits. The interim final rules under MHPAEA (2010) included additional guidelines for testing parity compliance and applying parity requirements to non-quantitative treatment limitations (NQTLs).[i][17] The ACA established certain Essential Health Benefits (EHBs) that are required to be covered in individual and most small group plans.[18] EHBs include MH/SUD benefits, making them subject to MHPAEA. The final rules implementing MHPAEA (2013) provided additional clarifications on NQTLs.[19]

Additionally, the Consolidated Appropriations Act of 2021 (Appropriations Act) amended MHPAEA to require carriers to perform, document, and make available their NQTLs comparative analyses to the Departments of Labor, Health and Human Services, and Treasury or applicable state authorities, upon request.[20] The Appropriations Act provides an important new enforcement tool for mental health parity compliance.

2.3 Effectiveness of Mental Health Parity Legislation

MHPAEA generally requires that financial and treatment limitations, such as copayments and prior authorization requirements imposed by carriers, cannot be more restrictive than those that apply to medical/surgical benefits. There are many NQTLs,[ii] such as prior authorization, that can impact access to MH/SUD benefits.

Mental health parity legislation is intended to improve access to mental health services and decrease financial and other burdens historically placed on MH/SUD benefits. Research has shown that comprehensive mental health parity legislation can improve financial protection and improve appropriate utilization for individuals seeking MH/SUD care.[21] However, determining comparability of MH/SUD processes, in writing and in operation, can be complex. Processes like provider reimbursement rate-setting, and consequently, negotiating provider reimbursement rates, might result in disparate rates for MH/SUD services and result in provider shortages, and consequently, inadequate MH/SUD provider networks. A 2019 analysis of payment rates for Current Procedural Terminology (CPT) codes for office visits determined that primary care physicians in Massachusetts are paid 60% more than behavioral health providers when using the same CPT codes.[22] Mental health providers typically cite low reimbursement rates as a primary reason for not accepting certain insurance plans, and administrative burden as a secondary reason. As a result, treatment for many patients becomes unaffordable and inaccessible as they cannot pay out-of-pocket provider fees.[23]

Furthermore, some areas of mental health parity are more difficult to assess without targeted market conduct examinations or member surveys. The 2018 Massachusetts Health Reform Survey conducted by the Blue Cross Blue Shield of Massachusetts Foundation found that 38.7% of individuals surveyed did not receive needed behavioral health treatment in the prior year.[24] Additionally, they found that the primary problem for individuals with

[i] NQTLs are treatment limitations that are not numerically quantifiable that might limit the scope or duration of benefits.

[ii] Additional examples of NQTLs include: billing code restrictions, concurrent review, and fail-first protocols.

difficulty accessing behavioral health care was either that providers did not accept their insurance, or that providers were not accepting new patients.[25]

In their most recent MHPAEA Report to Congress (2022), the Departments of Labor, Health and Human Services and Treasury highlight the greater emphasis on MHPAEA enforcement under the Appropriations Act and report significant mental health parity deficiencies by carriers. At a time when MH/SUD services are even more important [related to the pandemic], the report emphasizes that enforcement will continue to ramp up, with an additional focus on reducing stigma that individuals with MH/SUD often face, as well as raising awareness amongst stakeholders of mental health parity protections.

3.0 Cost of the Bill

The bill would not increase current coverage of MH/SUD benefits, nor would it expand on federal mental health parity law requirements. Furthermore, all responding carriers currently cover rape-related mental or emotional disorders the same as other MH/SUD services. Therefore, if the bill were to pass, the cost would be immaterial and assumed to be zero.

This report used the following sources to support its findings:

- Information about the intended effect of the bill, gathered from legislative sponsors
- Information, including descriptions of current coverage, from responses to a survey of commercial health insurance carriers in the Commonwealth
- Academic literature, published reports, and population data, cited as appropriate

4.0 Conclusion

The COVID-19 public health emergency (PHE) has led to social isolation, job loss, illness, and death of loved ones—and research shows increased rates of anxiety, depression, and other MH/SUD conditions have increased in response. Consequently, more adults are seeking care for MH/SUD. The bill would not increase carriers' mandated coverage or mental health parity requirements. However, it would replace the current definition of "biologically-based" with a broad, inclusive definition, and codify federal law into the Massachusetts state law. The bill might have the effect of increasing the awareness of mental health parity.

Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 2065, "An Act to Update Mental Health Parity." Accessed April 8, 2022: **https://malegislature.gov/Bills/192/H2065**.

[2] Maximum awards; compensable expenses. MGL 258C Section 3. Accessed June 6 2022: **General Law - Part III, Title IV, Chapter 258C, Section 3 (malegislature.gov)** .

[3] 2022 MHPAEA Report to Congress. Accessed June 6 2022: **https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf**.

[4] Op. cit. Mental Health in Massachusetts. KFF. Accessed May 10, 2022. **https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/massachusetts/#:~:text=The%20share%20of%20adults%20in,the%20U.S.%20share%20(19.9%25)**.

[5] Op. cit. Mental Health in Massachusetts. KFF.

[6] Op. cit. Mental Health in Massachusetts. KFF.

[7] Op. cit. Mental Health in Massachusetts. KFF.

[8] Op. cit. Mental Health in Massachusetts. KFF.

[9] Op. cit. Mental Health in Massachusetts. KFF.

[10] Op. cit. Mental Health in Massachusetts. KFF.

[11] 2022 MHPAEA Report to Congress. Accessed June 6 2022. **https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf**.

[12] Van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug and Alcohol Dependence, 131(1-2), 23–35. Accessed June 6 2022. **https://pubmed.ncbi.nlm.nih.gov/23490450/**.

[13] Pub. L. No. 104-204, Tit. VII, § § 701-702, 100 Stat. 2874, 2944-50 (Sept. 26, 1996).

[14] M.G.L. c 175 Section 47B(g); M.G.L. c 176 Section 8A(g); M.G.L. c. 176B Section 4A(g); M.G.L. c. 176G Section 4M(g)

[15] Mental Health Parity. Mass Legal Help. Accessed May 10, 2022. **https://www.masslegalhelp.org/mental-health/mental-health-parity**.

[16] Pub. L. No. 110-343, Div. C, Tit. V, Sub. B, §§ 511-512, 122 Stat. 3765, 3881-93 (Oct. 3, 2008).

[17] 75 Fed. Reg. 5410 (Feb. 2, 2010).

[18] Pub. L. No. 111-148, §§ 1201, 1302, 1311(j), 124 Stat. 119, 161, 163-64, 181 (Mar. 23, 2010).

[19] 78 Fed. Reg. 68,420 (Nov. 13, 2013).

[20] Consolidated Appropriations Act. Accessed June 6, 20022. **https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf**.

[21] Sipe TA, Finnie RK, Knopf JA, et al. Effects of mental health benefits legislation: a community guide systematic review. *Am J Prev Med*. 2015;48(6):755-766. doi:10.1016/j.amepre.2015.01.022. Accessed June 6, 2022. **www.ncbi.nlm.nih.gov/pmc/articles/PMC4700502/**.

[22] Mass.gov. AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More Than One Million Residents. Accessed May 3, 2022. **https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services-for-more-than-one-million-residents**.

[23] Op. cit. Mass.gov. AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More Than One Million Residents. Accessed May 3, 2022.

[24] 2018 Massachusetts Health Reform Survey. Blue Cross Blue Shield Massachusetts Foundation.

[25] Op. cit. 2018 Massachusetts Health Reform Survey. Blue Cross Blue Shield Massachusetts Foundation.