

# **Mental Health Access and the Regulation of Commercial Health Insurance**

**New Hampshire Insurance Department**

**NH Behavioral Health Summit  
December 9, 2025**



# Agenda

- ▶ Overview of the New Hampshire Insurance Department
- ▶ Basics of Insurance Regulation
- ▶ Role of Consumer Services Unit
- ▶ Our Behavioral Health Advisory Committee
- ▶ Mental Health Parity Primer and Mental Health Parity and Addiction Equity Act (MHPAEA)
- ▶ Department Highlights for MHPAEA Enforcement





# New Hampshire Insurance Department

- ✓ The New Hampshire Insurance Department was established in 1851, the first insurance regulatory agency in the United States.
- ✓ The mission of the New Hampshire Insurance Department is to promote and protect the public good by ensuring the existence of a safe and competitive insurance marketplace through the development and enforcement of the insurance laws of the State of New Hampshire. We are committed to doing so in an honest, effective and timely manner.
- ✓ State based regulation with coordination from the National Association of Insurance Commissioners (NAIC)



# What is Insurance?

- ▶ An arrangement by which an insurance company agrees to provide compensation for a specified loss.
- ▶ Concept has been around for nearly 4,000 years
- ▶ First Health insurance plans:
  - ▶ Marine Hospital Fund 1798
  - ▶ "Sickness Funds" early 1900s
  - ▶ Baylor University plan 1929
- ▶ Managed Care and the Affordable Care Act



# How is Insurance Regulated?

- ▶ State-Based Regulation
- ▶ Began with states granting special charters to companies to engage in the insurance business
- ▶ Over time, common sets of rules and requirements developed for specific types of insurance companies within each state.
- ▶ Many of these requirements still exist today including posting bonds, having a designated agent, the payment of premium taxes, and the filing of an annual report.
- ▶ 1851 – NHID becomes first formal state regulatory agency for insurance
- ▶ 1869 - Paul v. Virginia, 75 U.S. 168 (Insurance is not Interstate Commerce)
- ▶ 1871 – NAIC is formed to facilitate coordination among the states
- ▶ 1944 – US v. South-Eastern Underwriters Assn (overturns Paul v. Virginia)
- ▶ 1945 - McCarran-Ferguson Act
- ▶ 1974 – Employee Retirement Income Security Act
- ▶ 2008 - Mental Health Parity and Addiction Equity Act
- ▶ 2010 – Affordable Care Act



# New Hampshire Insurance Department

- ✓ Company licensing
- ✓ Financial Regulation
- ✓ Producer Licensing
- ✓ Form and Rate Review
- ✓ Market Conduct
- ✓ Consumer Services
- ✓ Premium Tax
- ✓ Data Analytics
- ✓ Advise Policymakers on issues related to insurance

The NHID has an in-house Consumer Services division that can assist providers and insurance consumers with insurance questions or concerns, including with behavioral health coverage. They can be contacted at (800) 852-3416, [consumerservices@ins.nh.gov](mailto:consumerservices@ins.nh.gov), and <https://insurance.nh.gov>.



# Behavioral Health Advisory Committee

- ▶ In November 2023, the Department reconstituted the Behavioral Health Advisory Committee, which had been dormant since 2021 due to challenges posed by the Covid-19 pandemic
- ▶ Mental Health is a top priority of Commissioner Bettencourt, and the revival of Behavioral Health Advisory Committee underscores the Department's dedication to improving mental health and substance use disorder services to New Hampshire residents



# Behavioral Health Advisory Committee

**The BHAC is a forum for carriers, providers and other interested parties to collaborate and problem solve**

This committee meets quarterly, and is comprised of:

- SUD Treatment Providers
- Mental Health Providers
- Health Care Provider Advocates
- SUD Treatment and Mental Health Advocates
- Consumer Advocates
- Insurance Companies
- NH Department of Health and Human Services (DHHS)

*Members of the public are welcome and encouraged to attend*



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# Behavioral Health Advisory Committee

A glimpse of some of the issues and initiatives that have recently been brought forth through the BHAC

- Dedicated several meetings to demystify credentialing and contracting processes and timelines. A resource document was produced with contacts by insurance company for BH contracting and is posted to the NHID website
- Highlighted care management and outreach programs related to behavioral health that insurance companies have in place for their members
- Addressed insurance company policies on billing for same day appointments with different providers
- Educated members on topics such as retroactive denial laws (aka 'clawbacks') and eating disorder coverages



# Behavioral Health Advisory Committee

A glimpse of some of the issues and initiatives that have recently been brought forth through the BHAC *(cont.)*

- Reviewed bulletins issued by the Department around coverage issues for BH integration services and MH services by state-sponsored Community Mental Health Providers for children under 21.
- Held a BH provider virtual town hall- an interactive listening session for providers and insurance companies to come together and discuss hot topic issues
- Guest speakers have included experts from NH Office of Professional Licensure and Certification, NH Dept of Health and Human Services and New Hampshire Hospital
- All health insurance companies have presented on their care coordination programs as well as their contracting and credentialing processes



# Behavioral Health Advisory Committee

A look back.... some of the topics that have been addressed by the BHAC since its inception in 2016:

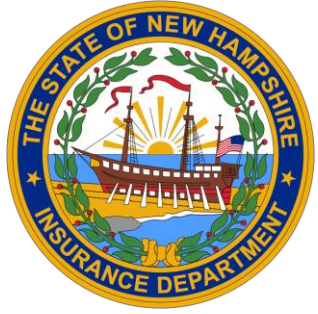
- ❖ Reviewed how market conducts examinations are undertaken and highlighted recently completed exams and associated corrective action plans. For example, how carriers provide coverage for Substance Use Disorder and whether benefits are consistency applied and not subject to more stringent requirements than med/surg benefits.
- ❖ The Department's examination of how health insurance companies handle preauthorization, claim denials, and utilization review practices for substance use disorder claims
- ❖ Specific issues- such as a case study of Medication Assisted Treatment for opioid addicted patients and considerations as it relates to insurance coverage and ongoing treatment
- ❖ Other states' input on what changes to federal regulations could help in combating the opioid crisis



# Behavioral Health Advisory Committee

A look back... some of the topics that have been addressed by the BHAC since its inception in 2016 *(cont)*:

- ❖ The Department's Annual Hearing overview of special topics and key findings
- ❖ Behavioral Health workforce development
- ❖ Projects overview and disposition of grants received by the Department
- ❖ Emergency Room boarding and legislative efforts to address the issue
- ❖ Provider experience with telemedicine implementation during COVID pandemic
- ❖ Current or pending legislation review and discussion



# Recent Major Shifts in Regulations

- ▶ Landscape of behavioral health benefits pre-2008
- ▶ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
- ▶ Affordable Care Act – 2010
- ▶ NHID's current efforts and priorities





# Health Insurance before MHPAEA and the ACA

- ▶ Former legislation had many loopholes and exceptions.
- ▶ Health insurance generally used to either openly have discriminatory practices related to MHSUD coverage or didn't cover it at all.
- ▶ Large disparities in cost-sharing between MHSUD and MEDSURG benefits. For example: Often you would see copayments for MEDSURG and co-insurance (generally more expensive) for MHSUD.
- ▶ Distinction between what is categorized as MHSUD and MEDSURG was inconsistent and usually designed to the disadvantage of the patient.
- ▶ In many instances there were different levels of coverage for "biologically based" disorders vs. "non-biologically based" mental health conditions.



# Mental Health Parity

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

- Aims to prevent health insurers from imposing benefit limitations on mental health or substance use disorder (MH/SUD) benefits that are more restrictive than the limitations placed on medical/surgical benefits
  - Aggregate lifetime
  - Annual dollar limits
  - Cost-sharing and deductibles
  - Limits and caps on the number of visits
  - Other treatment limitations



# MHPAEA Big Picture

## DOES:

- Treatment limitations for MH/SUD cannot be more stringent than treatment limits for MED/SURG benefits

## DOES NOT:

- Require coverage of mental health or substance use disorder services
- Prohibit treatment limitations
- Require insurers to contract with mental health providers



# Health Plans Subject to MHPAEA

## SUBJECT TO MHPAEA

- ▶ Health Insurance plans
- ▶ Employer sponsored group health plans
- ▶ Medicaid managed care plans
- ▶ CHIP
- ▶ Federal Employee Health Benefit Plan

## NOT SUBJECT TO MHPAEA

- ▶ Medicare
- ▶ 100% Medicaid Fee for Service
- ▶ Some grandfathered small group plans. Grandmothered transitional small group plans. (none left in NH)
- ▶ Small group (<50 employees) self-funded employee benefit plans



# MHPAEA Enforcement

- ▶ Federal Department of Labor (DOL) - Employee Benefits Security Administration (EBSA): Group Health Plans
- ▶ Federal Department of Health and Human Services (DHHS) - Centers for Medicare and Medicaid (CMS): Joint authority with the states
- ▶ State DHHS: Medicaid Managed Care plans
- ▶ States: Fully-insured group and Individual health insurance plans
  - ▶ NHID enforced MHPAEA in New Hampshire
  - ▶ RSA 417-E grants NHID authority to enforce MHPAEA



# Mental Health Parity Concepts Treatment Limitations

## Quantitative (Numerical Limitations)

- ▶ Financial Burden
  - ▶ Copays
  - ▶ Deductibles
  - ▶ Co-insurance
  - ▶ Out of Pocket Maximums
- ▶ Visit Limitations
  - ▶ Session Limits
  - ▶ Day Limits

## Non-Quantitative (other strategies, processes, or criteria for limitation)

- ▶ "What hoops do I need to jump through?"
- ▶ Prior Authorization
- ▶ Formulary Design
- ▶ Network Design
- ▶ Step Therapy
- ▶ Concurrent Review



# Mental Health Parity Concepts

Treatment limits for health insurance benefits for Mental Health must be no more restrictive than those provided for Physical Health.

**Physical Health Benefits** (Medical and Surgical Benefits) Med/Surg



**Mental Health Benefits** (Mental, Behavioral, and Substance Use Disorder Benefits) MH/SUD

Example:

Med/Surg has a deductible of \$500 and MH/SUD has a separate deductible of \$1,000.

\$500 < \$1,000 **PARITY VIOLATION**



# Classifications

- ▶ Benefits within six classifications are all considered separately.
  - ▶ Inpatient, In Network
  - ▶ Outpatient, In Network
  - ▶ Inpatient, Out of Network
  - ▶ Outpatient, Out of Network
  - ▶ Emergency Care
  - ▶ Pharmacy/Prescription Drugs



# Substantially All and Predominant Level

The health plan “may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.”

## Substantially All

If the limitation is applied to Med/Surg benefits, then it may comparably be applied to MH/SUD benefits in the same classification.

## Predominant Level

The level or stringency of limitation that can be applied to MH/SUD benefits in a classification.

The substantially all and predominant levels are evaluated and tested differently depending on the type of treatment limitation (QTL vs. NQTL).



# Quantitative Treatment Limitations

- ▶ Quantitative treatment limitations (**QTL**) can be expressed numerically.
- ▶ Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums.
- ▶ Types of other QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage.



# Testing Quantitative Treatment Limitations

## ▶ Substantially All test

- ▶ Applied first and is used to determine if the limitation can be used for MH/SUD benefits in the classification being tested
- ▶ 2/3 Threshold
- ▶ For example: A plan applies a copay to 70% of Med/Surg benefits for outpatient, in-network services. Because 70% is greater than 2/3, then co-pays can also be used for MH/SUD outpatient, in-network benefits.

## ▶ Predominant Level test

- ▶ If a QTL passes the Substantially All Test, then the Predominant Level Test is used to determine what level of the limitation can be applied to MH/SUD Benefits.
- ▶ The plan can only apply the QTL to MH/SUD benefits at a level that applies to at least 50% of the Med/Surg benefits in the same classification.
- ▶ For example: Of the 70% of med/surg benefits that apply a copay, 60% apply a \$30 copay, 10% apply \$40, and 20% apply \$20. \$30 is the predominant level since it is greater than 50%. Copays applied to MH/SUD benefits in this classification can only be \$30 or less.



# Non-Quantitative Treatment Limitations

- ▶ Non-Quantitative treatment limitations (**NQTL**) are other treatment limitations that cannot be expressed numerically.
- ▶ These include but are not limited to Prior Authorization, Network Design, Formulary Design, Concurrent Review, Step Therapy.
- ▶ Must be comparable to and applied no more stringently for MH/SUD benefits as it is for Med/Surg benefits in the same classification.
- ▶ This applied to both how the process or limitation is written in the plan/policy as well as how these rules are applied in operation.



# NQTL: Comparative Analysis

- ▶ The federal parity rule outlines how to test mental health parity when it comes to non-quantitative treatment limitations through the use of comparative analysis.
  - ▶ No straightforward calculation and thresholds as there is with QTL substantially all and predominant level testing.
- ▶ Each issuer should complete a Comparative Analysis for each NQTL used by the plan.
  - ▶ These can be requested by both regulators and consumers at any time.
- ▶ Steps for the comparative analyses are finely detailed in MHPAEA and include comparing processes "As written" and "In Operation".
  - ▶ Questions how the limitation was designed "on paper" as well as how it was actually applied in "real life" and compares these processes for Med/Surg vs. MH/SUD benefits in each classification.



# NQTL: Comparative Analysis

## 42 USC § 300gg-26 (a)(8)(A)

**(i)** The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

**(ii)** The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

**(iii)** The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

**(iv)** The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

**(v)** The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.



# Patient Protection and Affordable Care Act (ACA)

- ▶ Signed into law by President Barack Obama on March 23, 2010
- ▶ Mostly implemented by 2014, with some provisions phasing in by 2020
- ▶ Dramatic overhaul to the individual health insurance market, with some changes to group/employer plans
- ▶ Uninsured rates
  - ▶ 2010: 15.5% US, 11.1% NH
  - ▶ 2024: 8.2% US, 4.5% NH



# Patient Protection and Affordable Care Act (ACA)

- ▶ Guaranteed Issue
  - ▶ Community Rating
  - ▶ No Annual or lifetime caps on EHB
  - ▶ Required maximum out-of-pocket (MOOP) payment cap
  - ▶ Preventive care, vaccinations and medical screenings cannot be subject to co-payments, co-insurance or deductibles
  - ▶ Established Metal Level plans to represent relative out-of-pocket costs
    - ▶ 60% Bronze
    - ▶ 70% Silver
    - ▶ 80% Gold
    - ▶ 90% Platinum
  - ▶ Required appeals process for coverage determinations
  - ▶ Implement a Medical Loss Ratio (MLR)
    - ▶ 80% individual and small group markets
    - ▶ 85% large group market
  - ▶ Established Exchanges
  - ▶ Created advanced premium tax credit (APTC) subsidies and cost-sharing subsidies
  - ▶ Created Risk Adjustment transfers
  - ▶ Led to Medicaid Expansion
  - ▶ Allowed dependents to stay on the parents' insurance plan until age 26
- ▶ Essential Health Benefits (EHB)
    - ▶ Ambulatory patient services
    - ▶ Emergency services
    - ▶ Hospitalization
    - ▶ Maternity and newborn care
    - ▶ Mental health and substance use disorder services, including behavioral health treatment
    - ▶ Prescription drugs
    - ▶ Rehabilitative and habilitative services and devices
    - ▶ Laboratory services
    - ▶ Preventive and wellness services and chronic disease management
    - ▶ Pediatric services, including oral and vision care



# New Hampshire Insurance Regulations

- ▶ Requires coverage of the mental health and substance use disorders
- ▶ NHID is charged with enforcing MHPAEA in the insurance market
- ▶ RSA 420-J Managed Care Law
  - ▶ Utilization management
  - ▶ Prior Authorization
  - ▶ Claims processing
  - ▶ Appeals and External Review
  - ▶ Prescription Drug requirements
  - ▶ Emergency Services
  - ▶ Network Management



# NHID's Approach to Mental Health Parity

## ▶ Regulatory Oversight over health insurance plans

- ▶ Forms examiners review plans for compliance before they get to the market
- ▶ Market Conduct examinations catch violations
- ▶ Consumer Services
- ▶ Legal/Enforcement

## ▶ Regulatory Tools

- ▶ QTL Tool
- ▶ NQTL – Comparative Analysis
- ▶ Network Adequacy
- ▶ Prescription Drug/Formulary Review
- ▶ Policy and Rulemaking
- ▶ Outreach and Education



# NHID MHPAEA Tools

## QTL Tool

- ▶ NH has developed a tool to test quantitative treatment limitations for compliance with MHPAEA
- ▶ Uses the substantially all and predominant level tests outlined in the federal rule to highlight any potential violations prior to the plan being available in the market.
- ▶ Working towards requiring all health insurers complete this review and to address any identified issues.
- ▶ First reviews and testing were for Qualified Health Plans only.

## NQTL Comparative Analysis

- ▶ NH led an NAIC NE Zone Symposium
  - ▶ January of 2025
  - ▶ Collaboration with other state regulators resulted in the development of a template for comparative analysis.
  - ▶ First focus on Prior Authorization
- ▶ Initial Template Results/First round of insurer submissions
  - ▶ Heavy lift for both our Department as well as the issuer to successfully complete
  - ▶ Continued work with issuers to get a complete analysis
  - ▶ Checking for compliance "red-flags"
  - ▶ Gathering feedback for next round of examination, tool development, and continued compliance review.



# NHID Network Adequacy

- ▶ NHID approaches the evaluation of Network Adequacy differently than other regulatory bodies
- ▶ Service Basis vs. Provider Basis
  - ▶ Services outlined in our rule and tested in our review tool include MH/SUD services (CPT codes).
  - ▶ Allows MHPAEA angle in review/enforcement
- ▶ NH licenses non-physician providers to practice and bill independently
- ▶ Time and distance standards based on categories of services and population density of the county in question.
- ▶ Uses all payor claims database to confirm providers listed in network are actually providing (billing for) the services in question in addition to meeting time and distance standards.
- ▶ Network Adequacy review is not a direct test of mental health parity, but it can highlight potential violations that require further examination.



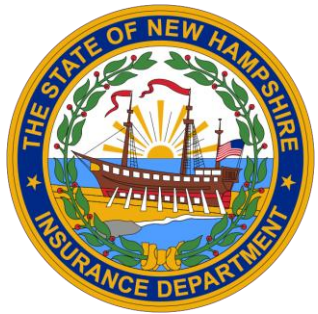
# NHID Prescription Drug/Formulary Review Tools

- ▶ Like Network Adequacy, our review of Prescription Drug coverage and formularies can show red-flags for parity issues but does not directly test for MHPAEA compliance.
- ▶ Checks for issues with adverse tiering, discriminatory formulary design, and clinical appropriateness.
- ▶ Our tools review coverage for specific drugs as well as limitations like step therapy and prior authorization, highlighting drug coverage for major conditions.
- ▶ In addition to high-cost physical health conditions like diabetes and some cancers, the review also includes MH/SUD conditions like bipolar disorder and schizophrenia.



# NHID Goals and Next Steps

- ▶ Mental healthcare access and MHPAEA compliance and enforcement continue to be a high priority for the NHID.
- ▶ Keeping up with ongoing changes that affect regulation – new legislation, political climate/uncertainty, hot topics.
- ▶ Rulemaking
- ▶ Tool development/updates
- ▶ Partnership with other states and regulatory bodies
- ▶ Professional Development and Education
- ▶ Public and Industry Outreach



ANY  
QUESTIONS  
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