State Mandates for Treatment for Mental Illness and Substance Use Disorders

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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Gail K. Robinson
Jerome B. Connolly
Melanie Whitter
Candy A. Magaña

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The authors of this report are Gail K. Robinson, Ph.D., vice president, Community and Behavioral Health Practice at Abt Associates, Inc.; Jerome B. Connolly, president, Connolly Strategies and Initiatives; Melanie Whitter, senior associate at Abt Associates, Inc.; and Candy A. Magaña, research assistant at Abt Associates, Inc. Shelagh Smith, M.P.H., provided assistance and guidance as the Government project officer and Jeffrey Buck, Ph.D, provided direction. Both are with the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA). Andrew McKinley of Netscan, a former division of the National Conference of State Legislators, also contributed to the development of this report.

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Office of the Associate Director for Organization and Financing, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, One Choke Cherry Road, 6-1063, Rockville, MD 20857

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Introduction

The purpose of this report is to describe the current status of State-mandated insurance coverage for mental and substance use disorders, and to identify trends in this type of coverage. The report is organized into three main topics: State-mandates benefits; State laws regulating mental health and addiction treatment workers; and those workers' prescriptive authority to prescribe psychotropic medication.

1. State-mandated benefits for mental illness and substance use disorders

This section identifies States that require insurance companies to provide coverage for their insurees who have mental or substance use disorders. It also describes the type of coverage and diagnostic conditions to which the insurance applies. Typically, States use one of three methods to require insurance companies to cover behavioral health conditions:

- Mandated offering. Coverage that requires insurers to provide equal mental and physical health benefits *if the insurers choose to offer coverage* for behavioral health conditions.
- Mandated benefits. Coverage that requires insurance for *specific* behavioral health conditions.
- Parity. Coverage that requires insurance for behavioral health conditions *equal* to insurance provided for physical health conditions.

The tables in this section distinguish between these three types of insurance coverage.

2. State laws regulating behavioral health care workers

Behavioral health services are provided by a variety of mental health and addiction treatment professionals, many of whom are licensed or certified at the State level. The term "behavioral" in this report refers to mental conditions and substance use disorders. This section describes *how* States authorize them to practice subject to State licensure and/or certification standards.

3. Analysis of State-recognized prescriptive authority for psychotropic drugs

This section analyzes State-recognized prescriptive authority for psychotropic medication. A related section discusses jurisdictions that have considered or enacted legislation prohibiting school employees from requiring or recommending psychotropic drugs for children.

II. Methodology

This report was compiled in the second half of 2004. A review and analysis of existing State laws since the early 1970s was conducted to provide the background and context for examining State choices in mandating insurance coverage for behavioral health. In 2007, only the section on prescriptive authority was updated.

1. State-mandated benefits for behavioral health care

The information on State-mandated benefits for behavioral health coverage relies on an analysis of State laws conducted by the Health Policy Tracking Service, a division of Netscan, formerly affiliated with the National Conference of State Legislators, which has been tracking State legislative developments with respect to behavioral health coverage requirements for several years.

This information was supplemented by a State-by-State review of more recently passed or amended statutes, which enabled a comparison of behavioral health laws from a chronological as well as a content perspective. A review of law and regulation reveals the myriad ways States have elected to address insurance coverage specifically for mental illness and substance use disorders, including inpatient and outpatient scope of benefits, copay amounts, coinsurance requirements, and annual and lifetime dollar limits, all in comparison with the same categories for physical illness.

In addition, the report required an analysis of the types of coverage required by States with respect to mental and substance use disorders, including the coverage definitions referred to above and the various limits, qualifications, and exemptions employed by States.

2. State laws regulating behavioral health care workers

State laws and regulations regarding qualified mental health and addiction treatment workers were identified using Lexis-Nexis®. Relevant information regarding licensure; regulation; scope of practice, including prescriptive authority; and mental health and addiction treatment professionals was also obtained from professional organizations and Web sites.

3. Analysis of State-recognized prescriptive authority for psychotropic drugs

State laws and regulations granting prescriptive authority to specified mental health and addiction professionals were identified using Lexis-Nexis®. In addition, any relevant information regarding prescriptive authority and related scope of practice issues was obtained from professional organizations and Web sites.

III. State Mandated Benefits

A. History of State Legislative Action on Mental Illness and Substance Use Disorders[1] Coverage

Initial Focus on Substance Use Disorders

State legislation has been used to require insurers to provide coverage for specific health conditions. Coverage of mental illness and substance use disorders was considered by legislatures more than 30 years ago when, in 1974, California passed a mandated offering bill on mental illness. In 1979, Alabama, Mississippi, and South Dakota enacted legislation requiring health insurers (group health insurers and health maintenance organizations (HMOs)) to cover 30 days of treatment for alcoholism.

In the early 1980s, additional States, primarily in the South, passed *mandated benefit* or *mandated offering* laws on substance use disorders. In the mid- to late-1980s, three other jurisdictions—Ohio, Washington, and Hawaii—enacted legislation on substance use disorders similar to California's *mandated offering* statute for mental illness. Despite activity around mental health issues in a few States, the majority of legislative activity in the 1970s and 1980s related to substance use disorders, specifically alcoholism. During this period, 10 States enacted *mandated offering* laws for substance use disorders, and 7 passed legislation requiring substance use disorders benefits (Table 1).

Movement to Parity Legislation in the Early 1990s

Parity legislation requires equal coverage for physical and mental illnesses. Another approach States may take is to require *mandated benefits* for certain conditions. A third type, or *mandated offering*, requires insurers to provide equal mental and physical benefits only if they choose to offer coverage of such behavioral health conditions. Examples of each type of State legislation are described in States listed below.

Vermont, Kansas, and Alabama provide perhaps the clearest examples of these types of legislative requirements. Alabama is considered a *mandated offering* State, as it requires health care service plans and health maintenance organizations to treat mental and physical illnesses equally *if the insurers choose to offer coverage* of such behavioral health conditions. Kansas is a *mandated benefit* State, as State law requires insurers to provide coverage for substance use disorders and mental illness, and the minimum inpatient and outpatient coverage is specified. Perhaps the strongest *parity* law among the States is that of Vermont, which requires equal coverage for physical and mental illness (including substance use disorders).

Table 1. Early Trends in State Law Mandating Behavioral Health Coverage

Year	State	Mandated offering or mandated benefit	Type
1974	CA	Mandated offering	Mental illness
1975	MS	Mandated benefit	Alcoholism
1979	AL	Mandated offering	Alcoholism
1979	SD	Mandated offering	Alcoholism
1980	KY	Mandated offering	Alcoholism
1981	OR	Mandated offering	Alcoholism
1981	TX	Mandated benefit	Substance use disorders
1982	LA	Mandated offering	Substance use disorders
1982	TN	Mandated offering	Substance use disorders
1984	ME	Mandated benefit	Substance use disorders
1985	NJ	Mandated benefit	Alcoholism
1985	NC	Mandated offering	Substance use disorders
1985	OH	Mandated benefit/mandated offering	Alcoholism/Mental illness
1986	MN	Mandated benefit	Substance use disorders
1987	AR	Mandated offering	Substance use disorders
1987	NM	Mandated offering	Alcoholism
1987	WA	Mandated offering	Mental illness
1988	HI	Mandated benefit	Mental illness
1989	PA	Mandated benefit	Substance use disorders
1991	MA	Mandated benefit	Alcoholism

Parity

During the 1990s, States increased enacting mental health parity legislation rather than focusing on mandated benefits for treatment of substance use disorders and alcoholism provisions. In 1991, North Carolina and Texas were at the forefront of this trend when the first parity statutes requiring equal insurance coverage for mental and physical illnesses became law in those States. Before that year, no jurisdiction had required parity coverage. These two States applied the law's requirements to limited populations, however, targeting benefits to those insured through the State employee health plan.

In 1993, Maryland did not pass comprehensive parity legislation, but enacted a mandated benefit law for mental illness and substance use disorders that included similar provisions. The statute prohibited any contract providing health care benefits from discriminating against people with mental illness, emotional disorders, or substance use disorders, and required insurers to cover treatment and diagnosis of those conditions under the same terms applied to physical illness.

Laws Approaching Parity Become the Norm in State Legislation

By 1996, the number of States following the trend toward parity laws had more than doubled with the addition of mandated mental health benefits in New Hampshire and Rhode Island (1994), mental illness and substance use disorders parity in Minnesota, an amendment to an existing limited parity law in Maine (1995), and legislative resolutions requiring a study of the issue in Louisiana and Oklahoma (1996).

Legislatively, 1997 was a landmark year for State action on this issue. Governors in Arkansas, Colorado, Connecticut, and

Vermont signed bills requiring parity in health insurance coverage between mental illness and physical conditions. The Vermont law, which included treatment for alcohol and substance use disorders, is still considered by many to be the most comprehensive law in the country.

Bills in 11 other States—Arizona, Delaware, Indiana, Kansas, Louisiana, Montana, Nevada, North Carolina, South Carolina, Tennessee, and West Virginia—were enacted to comply with the Federal Health Insurance Portability and Accountability Act. These measures included limited mandates comparable to those enacted by Congress in 1996. While the laws required insurers to offer additional benefits, they did not mandate full parity.

Around the same time, North Carolina enacted a statute that applied only to the teachers' and State employees' comprehensive major medical plan. This measure expanded the State's existing parity law to include substance use disorders benefits.

In 1998, Delaware enacted a statute requiring parity insurance coverage between mental health services and other medical treatment, Tennessee passed a minimum mandated benefit for mental health, and South Dakota enacted limited parity legislation that required equal coverage for biologically based mental illnesses and all other illnesses.

The following year was also a momentous one for State legislation on these issues: 11 more States enacted bills. In 1999, Virginia adopted a mental health parity law, and 10 States followed its lead: bills were signed in Montana (equal coverage for biologically based or serious mental illnesses), New Jersey (limited parity), Oklahoma (mandated benefit), Nebraska (mandated offering), Hawaii (full parity for three serious mental illnesses), Nevada (limited mandated benefit), Connecticut (expansion of an existing parity law), Missouri (limited mandated benefit), Louisiana (limited parity), South Dakota (clarification of "biologically based mental illnesses"), and California (full parity for severe mental illnesses).

By 2000, 19 States had adopted some parity legislation for either mental illness, substance use disorders, or both. New Mexico enacted legislation requiring group health plans to provide both medical/surgical and mental health benefits, Massachusetts passed a mental health parity bill and a limited mandated benefit for substance use disorders, and South Carolina adopted a law requiring equal benefits for mental illness treatment and substance use disorders for State employees covered under the jurisdiction's health insurance plans. Alabama, Kentucky, and Utah enacted mandated offering laws.

In 2001, Arkansas was added to the list of "parity" States by passing legislation requiring equal treatment for mental health care covered by ARKids First, its Children's Health Insurance Program (CHIP). Illinois enacted a law that required full parity benefits for serious mental illness and minimum mandated benefits for other mental conditions. Delaware expanded its mental health parity statute to include substance use disorders.

During the same year, Maine adopted legislation requiring several State departments to study potential cost savings resulting from legislation requiring parity coverage for mental disorders, eating disorders, and substance use disorders. Oregon opted to create a joint interim task force to examine and make recommendations on achieving parity between mental and physical health benefits in insurance plans.

Kansas passed a bill requiring group health insurance plans, including HMOs that provided coverage for mental health benefits for the diagnosis and treatment of mental illnesses. It also mandated that the plans provide the same deductibles, coinsurance, and other limitations for mental and physical conditions.

Also in 2001, Mississippi enacted a law that required small employer plans to offer coverage for mental health treatment, and compelled large employers to provide benefits for mental health treatment. Indiana added a substance use disorders parity provision, if treatment was needed in conjunction with mental illness, to the State employee health plans, while Rhode Island expanded the definition of mental illness and passed minimum mandated benefit laws establishing maximum allowable limits on outpatient services.

States Revise Laws

Despite large increases in parity legislation in 2001, the year also signaled the first signs of revisions in the States. Perhaps the first indicator was when Texas legislators amended coverage provided to State employees to reduce benefits from full parity for serious mental illness to a minimum mandated benefit, and set limitations on inpatient and outpatient treatment. Despite these changes, however, the law continued to allow unlimited lifetime benefits, and set copayments, coinsurance, and annual limits equal to those for physical illness.

In 2002, State actions around parity legislation were mixed. While many legislatures considered parity bills with 28 States debating bills, only 8 of them adopted statutes. Alabama, Colorado, Maryland, Michigan, New Hampshire, and West Virginia passed expansive legislation, while Kentucky and New Jersey enacted laws that contained mitigating or compromising provisions. The most far-reaching of the measures was the parity law adopted in West Virginia.

Legislation in other States further circumscribed the breadth of existing parity laws. Kentucky increased by 1 (from 50 to 51 employees) the size of a company whose group health plan would be exempt from the mental illness parity requirement. New Jersey passed mental illness and substance use disorders provisions that applied only to plans that offered coverage for individuals. This law did not replace existing laws that required more extensive coverage, such as for group plans and State employee insurance, but instead stipulated the minimum scope of inpatient and outpatient benefits for individuals insured if the health plan offered coverage for biologically based mental illnesses and substance use disorders. The intent of the New Jersey statute was to provide individuals with a less expensive option than those offered by group policies.

Reversal Continues: States Blame Rising Costs on Mandated Benefits

In 2003, small employers began to assert that the steady rise in insurance costs was preventing them from offering additional coverage. They also asserted that a contributing factor was the increasing number of required benefits. In response, legislators began considering and enacting legislation that waived or provided exemptions from State mandates This action allowed insurers to offer reduced or "bare-bones" health insurance policies.

That year, four States—Colorado, Montana, South Dakota, and Texas—enacted legislation that allowed the sale of less expensive insurance policies that did not contain State-mandated benefits. Those laws eliminated previous requirements for mental illness and substance use disorders treatment.

In addition, Colorado and Maryland adopted legislation requiring a study and reassessment of the cost of existing mandates, including behavioral health requirements. In contrast, other States (Maine, Indiana, and North Dakota) continued to enact far-reaching legislation. Kansas and Hawaii amended or deleted the sunset clauses in their mental health benefit statutes, allowing those laws to continue.

In 2004, a more precipitous decline occurred in legislative activity considering parity bills. The drop can be attributed either to success (32 States had enacted parity and/or mandated benefits legislation); or suspicion (required benefits were suspected of increasing health insurance costs).

Law-making activity in 2003 and 2004 reflected a concern for, and analysis of, the role that mandated benefits had on insurance premium costs. For example, a statute enacted in Louisiana exempted health insurers from delivering, issuing, or renewing a health policy that included any additional or required mandated benefit from January 1, 2004, until December 31, 2008. The State also passed legislation allowing insurers or HMOs to offer "health flex benefit policies" (a type of "bare-bones" coverage) to small employers. These plans were not required to include State-mandated benefits.

In 2004, several State legislatures considered and passed laws creating exceptions to parity and/or mandated benefits, similar to the law adopted in Texas in 2001. For example, Kentucky enacted legislation that created a 3-year moratorium on (prohibiting the adoption of any new) mandated benefits and allowed insurers the option of declining from offering any additional State-mandated benefits through December 31, 2007. Washington adopted a statute permitting insurers to offer small employers policies featuring limited benefits. These plans did not include coverage for numerous services, such as mental health and chemical dependency treatment.

In the same year, legislators in Kentucky considered but did not pass legislation that would have permitted insurers to offer a catastrophic health benefit plan that excluded coverage of any or all State mandates. Washington legislators discussed but did not pass a measure that would have allowed insurers to offer small employers a stripped-down policy. The policy was not required to provide coverage for psychological and other services as long as there was disclosure, meaning purchasers were informed of the limitation in advance.

As 2005 began, the movement away from sweeping parity legislation was expected to continue. Nevertheless, prospects for legislation seemed likely in Iowa and Washington. Table 2.a depicts the chronological development of State legislation with respect to parity from 1995 to 2005. Table 2.b displays the same information alphabetically, by State.

Table 2.a. Chronology of State-Legislated Benefits by Year

State	*Year*	*Type*	*Terms and conditions*
North Carolina	1991	Parity	Mental illness
Texas	1991	Parity	Mental illness
Maryland	1993	Mandated benefit	Mental illness Substance use disorders
Minnesota	1994	Parity	Mental illness Substance use disorders
New Hampshire	1994	Mandated benefit	Mental illness
Rhode Island	1994	Mandated benefit	Mental illness
Maine	1995	Parity	Amendment
Louisiana	1996	Parity	Study
Oklahoma	1996	Parity	Study
Alaska	1997	Mandated offering	Federal Mental Health Parity Act
Arizona	1997	Mandated offering	Federal Mental Health Parity Act
Arkansas	1997	Parity	Mental illness
Colorado	1997	Parity	Mental illness
Connecticut	1997	Parity	Mental illness
Delaware	1997	Mandated offering	Federal Mental Health Parity Act
Indiana	1997	Mandated offering	Federal Mental Health Parity Act
Kansas	1997	Mandated offering	Federal Mental Health Parity Act
Louisiana	1997	Mandated offering	Federal Mental Health Parity Act
Montana	1997	Mandated offering	Federal Mental Health Parity Act
Nevada	1997	Mandated offering	Federal Mental Health Parity Act
North Carolina	1997	Parity	Substance use disorders Applied to State employees plan
North Carolina	1997	Mandated offering	Federal Mental Health Parity Act
South Carolina	1997	Mandated offering	Federal Mental Health Parity Act
Tennessee	1997	Mandated offering	Federal Mental Health Parity Act
Vermont	1997	Parity	Mental illness Substance use disorders
West Virginia	1997	Mandated offering	Federal Mental Health Parity Act
Delaware	1998	Parity	Mental illness
South Dakota	1998	Parity	Mental illness
Tennessee	1998	Mandated benefit	Mental illness
California	1999	Parity	Mental illness
Connecticut	1999	Parity	Mental illness (expansion)
Hawaii	1999	Parity	Mental illness
Louisiana	1999	Parity	Mental illness
Missouri	1999	Mandated benefit	Mental illness
Montana	1999	Parity	Mental illness
Nebraska	1999	Mandated offering	Mental illness
Nevada	1999	Mandated benefit	Mental illness
New Jersey	1999	Parity	Mental illness
Oklahoma	1999	Mandated benefit	Mental illness
South Dakota	1999	Parity	Clarification
Virginia	1999	Parity	Mental illness
Alabama	2000	Mandated offering	Mental illness
Kentucky	2000	Mandated offering	Mental illness Substance use disorders
Massachusetts	2000	Parity	Mental illness
New Mexico	2000	Mandated benefit	Mental illness
South Carolina	2000	Parity	Mental illness Substance use disorders Applied to State employees plan

Continued

Table 2.a. Chronology of State-Legislated Benefits by Year, continued

State	*Year*	*Type*	*Terms and conditions*
Utah	2000	Mandated offering	Mental illness
Arkansas	2001	Parity	Mental illness (expansion to CHIP)
Delaware	2001	Parity	Substance use disorders Added to parity laws
Illinois	2001	Parity	Mental illness
Indiana	2001	Parity	Substance use disorders Applied to State employees plan
Kansas	2001	Mandated offering	Mental illness
Mississippi	2001	Mandated benefit	Mental illness
Rhode Island	2001	Mandated benefit	Mental illness (expansion)
Texas	2001	Mandated benefit	Applied to State employees plan Retrenchment
Alabama	2002	Mandated offering	Mental illness (expansion)
Kentucky	2002	Mandated offering	Retrenchment
Maryland	2002	Mandated benefit	Mental illness Substance use disorders (expansion)
New Hampshire	2002	Mandated benefit	Substance use disorders Added to parity laws
New Jersey	2002	Mandated offering	Mental illness Substance use disorders Retrenchment
West Virginia	2002	Parity	Mental illness Substance use disorders
Colorado	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
Hawaii	2003		Extended sunset date
Indiana	2003	Mandated offering	Substance use disorders Added to parity laws
Kansas	2003		Extended sunset date
Maine	2003	Parity	Substance use disorders Added to parity laws
Michigan	2003	Mandated benefit	Mental illness Substance use disorders
Montana	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
North Dakota	2003	Mandated benefit	Mental illness Substance use disorders Expansion of existing parity statute
South Dakota	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
Texas	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
Kentucky	2004		Moratorium
Washington	2004		Bare-bones policies without mandated benefits

Table 2.b. Chronology of State-Legislated Benefits by State

State	*Year*	*Type*	*Terms and conditions*
Alabama	2000	Mandated offering	Mental illness
Alabama	2002	Mandated offering	Mental illness (expansion)
Alaska	1997	Mandated offering	Federal Mental Health Parity Act
Arizona	1997	Mandated offering	Federal Mental Health Parity Act
Arkansas	1997	Parity	Mental illness
Arkansas	2001	Parity	Mental illness (expansion to CHIP)
California	1999	Parity	Mental illness
Colorado	1997	Parity	Mental illness
Colorado	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
Connecticut	1997	Parity	Mental illness
Connecticut	1999	Parity	Mental illness (expansion)
Delaware	1997	Mandated offering	Federal Mental Health Parity Act
Delaware	1998	Parity	Mental illness
Delaware	2001	Parity	Substance use disorders Added to parity laws
Hawaii	1999	Parity	Mental illness
Hawaii	2003		Extended sunset date
Illinois	2001	Parity	Mental illness
Indiana	1997	Mandated offering	Federal Mental Health Parity Act
Indiana	2001	Parity	Substance use disorders Applied to State employees plan
Indiana	2003	Mandated offering	Substance use disorders Added to parity laws
Kansas	1997	Mandated offering	Federal Mental Health Parity Act
Kansas	2001	Mandated offering	Mental illness
Kansas	2003		Extended sunset date
Kentucky	2000	Mandated offering	Mental illness Substance use disorders
Kentucky	2002	Mandated offering	Retrenchment
Kentucky	2004		Moratorium
Louisiana	1996	Parity	Study
Louisiana	1997	Mandated offering	Federal Mental Health Parity Act
Louisiana	1999	Parity	Mental illness
Maine	1995	Parity	Amendment
Maine	2003	Parity	Substance use disorders Added to parity laws
Maryland	1993	Mandated benefit	Mental illness Substance use disorders
Maryland	2002	Mandated benefit	Mental illness Substance use disorders (expansion)
Massachusetts	2000	Parity	Mental illness
Michigan	2003	Mandated benefit	Mental illness Substance use disorders
Minnesota	1994	Parity	Mental illness Substance use disorders
Mississippi	2001	Mandated benefit	Mental illness
Missouri	1999	Mandated benefit	Mental illness
Montana	1997	Mandated offering	Federal Mental Health Parity Act
Montana	1999	Parity	Mental illness

Continued

Table 2.b. Chronology of State-Legislated Benefits by State, continued

State	*Year*	*Type*	*Terms and conditions*
Montana	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
Nebraska	1999	Mandated offering	Mental illness
Nevada	1997	Mandated offering	Federal Mental Health Parity Act
Nevada	1999	Mandated benefit	Mental illness
New Hampshire	1994	Mandated benefit	Mental illness
New Hampshire	2002	Mandated benefit	Substance use disorders Added to parity laws
New Jersey	1999	Parity	Mental illness
New Jersey	2002	Mandated offering	Mental illness Substance use disorders Retrenchment
New Mexico	2000	Mandated benefit	Mental illness
North Carolina	1991	Parity	Mental illness
North Carolina	1997	Parity	Substance use disorders Applied to State employees plan
North Carolina	1997	Mandated offering	Federal Mental Health Parity Act
North Dakota	2003	Mandated benefit	Mental illness Substance use disorders Expansion of existing parity statute
Oklahoma	1996	Parity	Study
Oklahoma	1999	Mandated benefit	Mental illness
Rhode Island	1994	Mandated benefit	Mental illness
Rhode Island	2001	Mandated benefit	Mental illness (expansion)
South Carolina	1997	Mandated offering	Federal Mental Health Parity Act
South Carolina	2000	Parity	Mental illness Substance use disorders Applied to State employees plan
South Dakota	1998	Parity	Mental illness
South Dakota	1999	Parity	Clarification
South Dakota	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
Tennessee	1997	Mandated offering	Federal Mental Health Parity Act
Tennessee	1998	Mandated benefit	Mental illness
Texas	1991	Parity	Mental illness
Texas	2001	Mandated benefit	Applied to State employees plan Retrenchment
Texas	2003		Mental illness Substance use disorders Retrenchment Bare-bones policies without mandated benefits
Utah	2000	Mandated offering	Mental illness
Vermont	1997	Parity	Mental illness Substance use disorders
Virginia	1999	Parity	Mental illness
Washington	2004		Bare-bones policies without mandated benefits
West Virginia	1997	Mandated offering	Federal Mental Health Parity Act
West Virginia	2002	Parity	Mental illness Substance use disorders

B. Federal Mental Health Parity Legislation

Influences of the Federal Parity Law

While States were grappling with parity legislation and mandated benefits for behavioral health issues, the same issues were being discussed and enacted at the Federal level, albeit much later.

In 1996, President Bill Clinton signed the Mental Health Parity Act, which prohibited group health insurers that offered mental health benefits from imposing more restrictive annual or lifetime limits on spending for mental illness than on physical conditions. Because the statute applied only if mental health benefits were offered in an insurance plan, it was generally considered to be a "*mandated offering*" law. The statute did not apply to cost sharing, nor did it include substance use disorders conditions. Moreover, employers with fewer than 50 employees could be exempt from the law's provisions if they expected to experience a premium increase of at least 1 percent due to the addition of the benefit.

After the law expired in December 2000, Congress considered a stronger, more comprehensive mandated offering bill in 2001. Despite some success in both chambers, the bill failed to survive a House-Senate conference committee. As an alternative, Congress extended the 1996 Mental Health Parity Act through December 2002. Later, the law was extended 1 more year, through December 2003. During this time, additional attempts to pass a mental health parity bill were unsuccessful. In the fall of 2003, Congress again extended the mental health parity statute through December 2005.

State Legislatures Respond to the Federal Law

The 1996 Federal act applies to all insurers and prohibits them from imposing annual or lifetime dollar limits that are more restrictive than those for other illnesses. But insurers are not prohibited from restricting office visits and hospital stays. The act does not preempt State law, but also does not require the States to enact it for it to take effect.

Fourteen States have adopted the Federal mental health parity (mandated offering) statute, and several States that have not done so have enacted their own mandated offering statute. Thus, most States mandate that coverage for mental health must be equal to that for physical conditions, *if* mental health coverage is offered.

In addition, many States have chosen to require a combination of coverage requirements. For example, Arkansas, which has not adopted the Federal law, mandates parity for mental illness yet has enacted mandated offering for substance use disorders conditions.

Still other States differentiate between types of insurance plans when enacting either parity or mandated offering requirements. For example, Minnesota mandates parity for mental illness and substance use disorders for individuals insured by HMOs. In contrast, mandated offering applies to those same maladies for people who are insured in group or individual health plans.

State statutes include myriad approaches to the amount of coverage received by an individual, such as the extent of inpatient, outpatient, and residential care; the size of copays; and allowable annual and lifetime dollar limits. Half of the States have elected to require the same inpatient and outpatient

benefits for mental health services as for physical illness. In others, day or visit limits have been adopted, and a few have specified a minimum annual dollar amount for the benefit. Slightly fewer States, but still nearly half, require parity between the residential (inpatient) benefits offered for physical illness and those provided for mental health. States handle copayments and deductibles in a number of ways. Most (31) require the same consideration for physical and mental health services.

Table 3 displays the mental illness and substance use disorders coverage provisions mandated by the States as of December 31, 2004. States adopting the Federal law and those enacting parity provisions of their own also are identified. The table also includes the scope of inpatient, outpatient, and residential benefits, and any provisions specifying a lifetime or annual dollar limit (compared with that for physical illness). Additionally, table 3 presents the 22 States that required parity at the end of 2004. Of those 22 States, 17 provide general parity, while the remainder provide parity for one or more of the following categories: serious mental illness, developmental disorders, biologically based mental illnesses, and behavioral health services covered by HMOs. In alphabetical order, the "parity" States are Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Vermont, Virginia, and West Virginia.

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Alabama	1979	No	Group and HMO		Alcoholism	Mandated offering	30 days	1 day of inpatient treatment converts to 3 sessions of outpatient treatment	1 day of inpatient treatment converts to 2 days of partial/residential treatment	Not specified	Not specified
Alabama	2001	No	Group and individual	Small employers of 50 or fewer	Mental illness	Mandated offering	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Alabama	2002	No	Health care service plans and HMOs		Mental illness	Mandated offering	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Alaska	1997	Yes (1997)	Group of 20 employees or fewer must offer coverage	Employers with 5 or fewer employees	Substance use disorders	Minimum mandated benefits or mandated offering for small groups	Not specified	Not specified	Not specified	Must be equal	At least $12,715 over 2 consecutive years and $25,425 lifetime
Arizona	1998	Yes (1997)	Group	Small employers of 50 or fewer or a premium increase of 1% or more	Mental illness	Mandated offering	Not specified	Not specified	Not specified	Must be equal	Must be equal
Arkansas	1987	No	Group and HMO		Substance use disorders	Mandated offering	Not less favorable, generally	Not less favorable, generally	Not less favorable, generally	Not less favorable, generally	$6,000 every 2 years and $12,000 lifetime

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Arkansas	1997	No	Group	Small employers of 50 or fewer or a premium increase of 1% or more	Mental illness and developmental disorders, substance use disorders	Parity for mental illness and developmental disorders, mandated offering for chemical dependency	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Arkansas	2001	No	Employers of 50 or fewer		Mental illness	Minimum mandated benefits	Must be equal (as stated in statute)	Must be equal (as stated in statute)	Must be equal (as stated in statute)	Must be equal	$7,500 lifetime
Arkansas	2001	No	Employers of 51 or more		Mental illness	Mandated benefit	8 days for larger employers (as stated in statute)	40 visits (as stated in statute)	8 days for larger employers (as stated in statute)	Must be equal	Must be equal
California	1974	No	Group		Mental illness	Mandated offering	Not specified	Not specified	Not specified	Not specified	Not specified
California	1990	No	Group		Alcoholism	Mandated offering	Not specified	Not specified	Not specified	Not specified	Not specified
California	2000	No	Group, HMO, and individual		Severe mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Colorado	1992	No	Group	2003 amendment provides an option for employers of 50 or fewer to purchase plans without a mandate	Mental illness with the exception of autism	Mandated benefit	45 days	Covered under major medical at not less than $1,000 annually	90 days	Limited to less than 50% of the total cost of treatment	Not less than $1,000 annually; lifetime limits not specified

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Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Colorado	1994	No	Group	2003 amendment provides an option for employers of 50 or fewer to purchase plans without a mandate	Alcoholism	Mandated offering	45 days	$500 annually	Not specified	Limited to less than 50% of the total cost of treatment	Not specified
Colorado	1998	No	Group	2003 amendment provides an option for employers of 50 or fewer to purchase plans without a mandate	Biologically based mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Connecticut	2000	No	Group and individual		Mental and nervous conditions, substance use disorders	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Delaware	1998	Yes (1997)	Group, HMO, individual, and State employee plans		Serious mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Delaware	2001	Yes (1997)	Group, HMO, individual, and State employee plans		Substance use disorders	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Florida	1992	Yes (1998)	Group and HMO		Mental illness	Mandated offering	30 days	$1,000 per benefit year	Up to the equivalent of 30 days	May differ after minimum benefits have been met	May differ after minimum benefits have been met
Florida	1993	Yes (1998)	Group and HMO		Substance use disorders	Mandated offering	Not specified	44-visit maximum; $35 maximum reimbursement per visit	Not specified	Not specified	Minimum lifetime benefit of $2,000; annual limits not specified
Georgia	1998	No	Group and individual		Mental illness including substance use disorders	Mandated offering	30 days	48 visits	Not specified	Must be equal	Must be equal
Hawaii	1988	No	Group, HMO, and individual		Mental illness	Mandated benefits	30 days	30 visits	1 day of inpatient treatment converts to 2 days of partial/residential treatment	Must be comparable	Must be comparable

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Hawaii	1988	No	Group, HMO, and individual		Substance use disorders	Mandated benefits	No fewer than 2 visits per lifetime	No fewer than 2 visits per lifetime	No fewer than 2 visits per lifetime	Must be comparable	Must be comparable
Hawaii	1999	No	Group and individual	Employers of 25 or fewer	Serious mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Idaho	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	1991	No	Group		Mental illness	Mandated offering	Not specified	Not specified	Not specified	Individuals may be required to pay up to 50% of the expenses	Benefits may be limited to the lesser of $10,000 or 35% percent of the lifetime policy limit.
Illinois	1995	No	Group		Alcoholism	Mandated benefits	Not specified	Not specified	Not specified	Not specified	Not specified
Illinois	2002	No	Group	Employers of 50 or fewer	Serious mental illness; mental illnesses other than serious mental illnesses	Parity for serious mental illnesses; mandated offering for less severe mental illnesses	Must be equal for serious mental illness; 45 days for less severe mental illnesses	Must be equal for serious mental illness; 35 days for less severe mental illnesses	Must be equal for serious mental illness; not specified for less severe mental illnesses	Must be equal for serious mental illness; individuals with less severe mental illness may pay up to 50% of expenses	Must be equal for serious mental illness; annual benefits for less severe mental illnesses may be limited to the lesser of $10,000 or 25% of lifetime policy limit
Indiana	1997 (sunset date extended in 2000)	Yes (1997)	Group, HMO, individual, and State employee plans	Small employers of 50 or fewer or a premium increase of 1% or more	Mental illness	Mandated offering	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/ residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Indiana	2001	Yes (1997)	State employee plans	Premium increase of 4% or more	Substance use disorders	Mandated offering for plans that offer coverage for mental illness	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Indiana	2003	Yes (1997)	Group, HMO, and individual		Substance use disorders	Mandated offering for plans that offer coverage for mental illness	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Iowa	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kansas	1998	Yes (1997)	Group, HMO, individual, and State employee plans		Substance use disorders and mental illness	Mandated benefits	30 days	Not less than 100% of the first $100, 80% of the next $100, and 50% of the next $1,640 per year; not less than $7,500 per lifetime	Not specified	Not specified	Only specified for outpatient treatment

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Kansas	2002	Yes (1997)	Group, HMO, and State employee plans for mental illness; group and individual for substance use disorders or nervous/mental conditions		Mental illness, substance use disorders, and nervous/mental conditions	Mandated offering for mental illness; mandated benefits for substance use disorders or nervous/mental conditions	45 days for mental illness; 30 days for substance use disorders or nervous/mental conditions	45 visits for mental illness; not less than 100% of the first $100, 80% of the next $100, and 50% of the next $1,640 per year; not less than $7,500 per lifetime for substance use disorder or nervous/mental conditions	Not specified	Equal if offered for mental illness; not specified for substance use disorders or nervous/mental conditions	Only specified for outpatient treatment
Kentucky	1980	No	Group		Alcoholism	Mandated offering	3 days of emergency detox reimbursed at $40 per day	10 visits reimbursed at $10 per visit	10 days reimbursed at $50 per day	Not specified	Not specified
Kentucky	1996	No	Group		Mental illness	Mandated offering	Must be equal	Must be equal	Not specified	Must be equal	Must be equal
Kentucky	2000	No	Group	Small employers of 50 or fewer	Mental illness and substance use disorders	Mandated offering	Equal if offered	Equal if offered	Equal if offered	Equal if offered	Equal if offered
Kentucky	2001	No	Group	Amends the law passed in 2000 to exempt employers of 51 or fewer							

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Louisiana	1982	Yes (1997)	Group		Substance use disorders	Mandated offering	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Louisiana	1982	Yes (1997)	Group, self-insured, and State employee plans		Mental illness	Mandated offering	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Louisiana	2000	Yes (1997)	Group, HMOs, and State employee plans		Serious mental illness	Mandated benefits	45 days	52 visits	1 day of inpatient treatment for mental illness is equivalent to 2 days of partial/residential treatment	Must be equal	Must be equal
Louisiana	2001	Yes (1997)	Group	Small employers or a premium increase of 1% or more	Mental health	Mandated offering	Not specified	Not specified	Not specified	Not specified	Equal if offered
Maine	1984	Yes (1997)	Group	Small employers of 20 or fewer	Alcoholism and drug dependency (as stated in statute)	Mandated benefits	Not specified	Not specified	Not specified	May place a maximum limit on benefits provided they are consistent with State law	May place a maximum limit on benefits provided they are consistent with State law
Maine	1996	Yes (1997)	Group and individual plans with 20 employees or fewer		Biologically based mental illness	Mandated offering	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Maine	1996	Yes (1997)	Group and HMOs	Small employers of 20 or fewer	Mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Maine	2003	Yes (1997)	Group and HMOs	Small employers of 20 or fewer	Mental illness; expands coverage to 11 categories of mental illness, including substance use disorders	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Maryland	1994	No	Individual and group		Mental illness, emotional disorders, substance use disorders	Minimum mandated benefit (statutory language; insurer can provide no less)	Must be equal	Unlimited visits	60 days	Must be equal with the exception of outpatient visits; 80% for 1-5 visits, 65% for 6-30 visits, 50% for more than 30 visits	Must be equal
Maryland	2002	No	Group and individual insurers, HMOs, and nonprofit health service plans		Residential crisis services defined as intensive mental health and support services	Minimum mandated benefit (statutory language; insurer can provide no less)	Not specified	Not applicable	Not applicable	Not specified	Not specified

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Massachusetts	1991	No	Group, HMO, and individual		Alcoholism	Mandated benefits	30 days	$500 annually	May convert 2 days of partial/residential treatment to 1 day of inpatient treatment	Not specified	Not specified
Massachusetts	1996	No	Group, HMO, and individual		Mental and nervous conditions	Mandated benefits	60 days in a mental hospital	$500 annually	May convert 2 days of partial/residential treatment to 1 day of inpatient treatment	Not specified	Lifetime maximum must be equal for inpatient treatment
Massachusetts	2001	No	Group, HMO, individual, and State employee plans	Small employers of 50 or fewer (law states that the exemption expired on 1/1/2002)	Biologically based mental illness and related cases; substance use disorders; all Diagnostic and Statistical Manual (DSM) diagnoses not covered under parity provisions	Parity for biologically based illnesses, mandated benefits for other DSM diagnoses	Must be equal for biologically based; 60 days for other DSM diagnoses	Must be equal for biologically based; 24 visits for other DSM diagnoses	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/ residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Michigan	1998	No	Group for inpatient; group and individual for other modes of treatment	Premium increase of 3% or more	Substance use disorders	Mandated offering for inpatient and mandated benefits for other treatments	To the extent agreed upon	$1,500 annually for outpatient and intermediate treatment	$1,500 annually for outpatient and intermediate treatment	Charges, terms, and conditions shall not be less favorable	$1,500 annually for outpatient and intermediate treatment
Michigan	2001	No	Group, HMO, and individual	Exemption from substance use disorder service if premiums increase by 3% or more	Mental health and substance use disorders	Minimum mandated benefit	None	Not fewer than 20 visits for mental health and $2,968 for substance use disorders	$2,968 for substance use disorders	Must be equal	Lifetime limits aren't specified; $2,968 annually for outpatient and intermediate care for substance use disorders
Minnesota	1986	No	Group and individual		Substance use disorders	Mandated benefits	At least 20% of the total days allowed but not fewer than 28 days annually	At least 130 hours of treatment annually	At least 20% of the inpatient days allowed but not fewer than 28 days annually	Not specified	Not specified
Minnesota	1995	No	Group, HMO, and individual		Mental illness and substance use disorders	Parity for HMOs; mandated offering for group and individual plans	Must be equal for both	Must be equal for both	Must be equal for both	Must be equal for both	Must be equal for both
Mississippi	1975	No	Group		Alcoholism	Mandated benefits	Not specified	Not specified	Not specified	Not specified	Annual limit of $1,000; lifetime limit not specified

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Mississippi	2002	No	Group and individual	Premium increase of 1% or more	Mental illness	Mandated offering for small employers of 100 or fewer and minimum mandated benefits for others	30 days	52 visits	60 days	Must be equal for inpatient and partial treatment; outpatient treatment must be a minimum of 50% of covered expenses	Must be equal
Missouri	1995	No	Group and individual		Substance use disorders	Mandated benefits for alcoholism; mandated offering for chemical dependency	30 days for alcoholism; 80% of reasonable charges; $2,000 maximum	30 total days for all levels of care	30 total days for all levels of care	Not specified	Not specified
Missouri	1997	No	Group, HMO, and individual		Mental illness and substance use disorders	Mandated offering	90 days for mental illness and 6 days for detox	2 visits for mental illness and 26 visits for substance use disorders	Must be equal for mental illness; 21 days for substance use disorders	Must be equal	Must be equal for mental illness; substance use disorders may not be limited to fewer than 10 episodes of treatment
Missouri	2000	No	Group and individual		Mental illness including substance use disorders	Mandated offering	Equal for mental illness; at least 30 days for substance use disorders if offered	Equal for mental illness; at least 20 visits for substance use disorders if offered	Not specified	Shall not be unreasonable in relation to the costs of services provided for mental illness	A lifetime limit equal to 4 times the annual limit may be imposed for substance use disorders

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Montana	1997	Yes (1997)	Group	Small group (unspecified number) or a premium increase of 1% or more	Mental illness and substance use disorders	Mandated benefits	21 days each with a $4,000 maximum every 2 years; $8,000 lifetime maximum for substance use disorders	No less than $2,000 for mental illness and $1,000 for substance use disorders annually	1 day of inpatient treatment for mental illness is equivalent to 2 days of partial treatment	No less favorable, up to maximums	Aggregate limits may not be imposed more restrictively
Montana	2000	Yes (1997)	Group and individual		Severe mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Montana	2001 (replaces 1997 law)	Yes (1997)	Group		Mental illness and substance use disorders	Mandated benefits	21 days for mental illness; $6,000 annual limit until $12,000 lifetime limit is met; annual benefits may then by reduced to $2,000 for substance use disorders	Not less than $2,000 for mental illness	1 day of inpatient treatment for mental illness is equivalent to 2 days of partial	No less favorable, up to maximums	Not specified
Nebraska	1989	No	Group and HMOs		Alcoholism	Mandated offering	30 days annually with at least 2 treatment periods in a lifetime	60 visits during the lifetime of the policy	Not specified	No less favorable, generally, than for physical illness	No less favorable, generally, than for physical illness
Nebraska	2000	No	Group and HMOs	Small employers of 15 or fewer	Serious mental illness	Mandated offering	Must be equal if offered	Must be equal if offered	Not specified	May be different	Must be equal if offered

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Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/ residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Nevada	1997	Yes (1997)	Group, HMO, and individual		Substance use disorders	Mandated benefits	$9,000 inpatient and $1,500 for detox per year	$2,500 annually	Not specified	Must be paid in same manner	Must be paid in same manner to maximum benefit; lifetime maximum not specified
Nevada	2000	Yes (1997)	Group and individual	Small employers of 25 or fewer or a premium increase of 2% or more	Severe mental illness	Mandated benefits	40 days	40 visits	1 day of inpatient treatment for mental illness is equivalent to 2 days of partial/ residential treatment	Must not exceed 150% of the out-of-pocket expenses required for medical and surgical care	Must be equal
New Hampshire	1995	No	Group		Biologically based mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
New Hampshire	2003	No	Blanket accident or health plans, group, HMO, nonprofit health service corporations, and State employee plans		Biologically based mental illness (amends the list from the 1995 law), substance use disorders, mental illnesses in the DSM other than biologically based illnesses	Parity for biologically based mental illness; minimum mandated benefits for substance use disorders and mental illnesses other than biologically based illnesses	Must be equal for biologically based illness; may be limited for substance use disorders, yet must provide benefits for detoxification and rehabilitation; benefits for mental illness other than biologically based must be equal to benefits provided on a basis other than a major medical basis	Must be equal for biologically based mental illness; benefits for substance use disorders may be limited, yet must include benefits for detoxification and rehabilitation; HMOs that offer benefits must cover 2 diagnostic visits and 3 treatment visits per contract year; for group or blanket insurers, at 15 hours per year	Must be equal for biologically based illness; not specified for substance use disorders; benefits for other mental illnesses must be equal for residential programs and outpatient services on a basis other than major medical	Must be equal for biologically based illnesses; not specified for substance use disorders; benefits for other mental illnesses must be equal except for coinsurance and HMOs may not exceed 20% of the reasonable and customary charge	Must be equal for biologically based illness; may be limited for substance use disorders; for other mental illnesses, benefits for inpatient, outpatient and partial hospitalization may be limited to not less than $3,000 annually and $10,000 per lifetime
New Jersey	1985	No	Group and individual		Alcoholism	Mandated benefits for care prescribed by a doctor	Must be equal	Must be equal	Must be equal	Benefits shall be provided to the same extent as for other illnesses	Benefits shall be provided to the same extent as for other illnesses
New Jersey	1999	No	Group and individual		Biologically based mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/ residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
New Jersey	2000	No	State employee plans		Biologically based mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
New Jersey	2002	No	Individual		Biologically based mental illness and substance use disorders	Mandated offering	90 days for mental illness; 30 days total for inpatient and/or outpatient treatment for substance use disorders	30 days for mental illness; 30 total days for inpatient and/or outpatient treatment for substance use disorders	Not specified	No coinsurance for mental illness, yet a $500 copayment per inpatient stay and a 30% coinsurance for outpatient visits; 30% coinsurance for substance use disorders	Not specified
New Mexico	1987	Yes (1998)	Group		Alcoholism	Mandated offering	30 days annually and no fewer than 2 episodes per lifetime	30 days annually and no fewer than 2 episodes per lifetime	Not specified	Consistent with those imposed on other benefits	Consistent with those imposed on other benefits
New Mexico	2000	Yes (1998)	Group	For employers of 49 or fewer, a premium increase of more than 1.5%; for employers of more than 50, a premium increase of more than 2.5%	Mental health benefits as described in the group health plan	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

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Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
New York	1998	No	Group		Mental illness including substance use disorders	Mandated offering	30 days for mental illness and substance use disorders; 7 days for detoxification	$700 for mental illness and 60 visits for substance use disorders	Not specified	As deemed appropriate by the superintendent and are consistent with those for other benefits	As deemed appropriate by the superintendent and are consistent with those for other benefits
North Carolina	1985	Yes (1997)	Group		Substance use disorders	Mandated offering	$8,000 per year and $16,000 per lifetime	$8,000 per year and $16,000 per lifetime	$8,000 per year and $16,000 per lifetime	$8,000 per year and $16,000 per lifetime	$8,000 per year and $16,000 per lifetime
North Carolina	1997	Yes (1997)	State employee plans		Mental illness and substance use disorders	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
North Dakota	1995	No	Group and HMO		Mental illness and substance use disorders	Mandated benefits	45 days for mental illness and 60 days for substance use disorders	30 hours for mental illness and 20 visits for substance use disorders	120 days for mental illness and substance use disorders	No deductible or copay for the first 5 hours, not to exceed 20% for the remaining hours	Not specified
North Dakota	2003	No	Group and HMO		Substance use disorders	Mandated benefits (amends the 1995 law)	45 days	No change	60 days; if additional treatment is required, up to 23 days of unused inpatient treatment may be traded at a rate of 1 inpatient day for 2 residential days	No change	No change

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Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Ohio	1985	No	Group and self-insured		Mental illness and alcoholism	Mandated offering for plans that offer mental health coverage; mandated benefits for alcoholism	At least $550 annually for mental illness and alcoholism	At least $550 annually for mental illness and alcoholism	At least $550 annually for mental illness and alcoholism	Benefits are subject to reasonable coinsurance and deductibles	Lifetime dollar limits are unspecified
Oklahoma	2000	No	Group	Small employers of 50 or fewer or a premium increase of 2% or more	Severe mental illness	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Oregon	1981	No	Individual		Alcoholism	Mandated offering	$4,500 in a 24-month period	$4,500 in a 24-month period	$4,500 in a 24-month period	Coverage must be no less than 80% of total expenses	Lifetime not specified
Oregon	2000	No	Group and HMO		Mental illness including substance use disorders	Mandated benefits	$5,625 for adults and $5,000 for children for the treatment of substance use disorders; $5,000 for adults and $7,500 for children per 24-month period for the treatment of mental illness	$1,875 for adults and $2,500 for children for the treatment of substance use disorders; $2,500 for adults and children per 24-month period for mental health treatment	$4,375 for adults and $3,750 for children for substance use disorder treatment; $1,250 for adults and $3,750 for children per 24-month period for mental health treatment	Will be no greater than those for other illnesses	For dual diagnosis for mental illness and substance use disorders, $13,125 for adults and $15,625 for children. For substance use disorders only, $8,125 for adults and $13,125 per 24-month period

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Pennsylvania	1989	No	Group and HMO		Substance use disorders	Mandated benefits	7 days of detoxification per year and 28 per lifetime	30 visits per year and 120 per lifetime	30 visits per year, 90 days per lifetime	For the first course of treatment, will be no greater than those for other illnesses	Dollar limits not specified; day and visit limits as specified for each level of care
Pennsylvania	1999	No	Group and HMO	Small employers of 50 or fewer	Serious mental illness	Mandated benefits	30 days	60 visits; 1 day of inpatient may be converted to 2 visits	Not specified	May not prohibit access to services	Must be equal
Rhode Island	1995	No	Group, HMO, individual, and self-insured		Serious mental illness	Parity	Must be equal	Must be equal	Not specified	Must be equal	Must be equal
Rhode Island	2002	No	Group, HMO, individual, and self-insured		Mental illness including substance use disorders	Minimum mandated benefit	Must be equal	30 visits for mental illness only; 30 visits for substance use disorders only; five detoxification occurrences or 30 days, whichever comes first	Must be equal	Must be equal	Must be equal
South Carolina	1994	Yes (1997)	Group		Mental illness including substance use disorders	Mandated offering	$2,000 annual limit	$2,000 annual limit	$2,000 annual limit	May be different	$10,000 lifetime maximum

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
South Carolina	2002	Yes (1997)	State employee plans	Premium increase of 1% by 12/31/2004 or 3.39% at any time between 1/1/2002 and 12/31/2004	Mental illness and substance use disorders	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
South Dakota	1979	No	Group, HMO, and individual		Alcoholism	Mandated offering	30 days of care overall each 6 months; 90 days lifetime	30 days of care overall each 6 months; 90 days lifetime	30 days of care overall each 6 months; 90 days lifetime	On the same basis as benefits provided for other illnesses	On the same basis as benefits provided for other illnesses
South Dakota	1998	No	Group, HMO, and individual		Biologically based mental illness (definition is narrowed by a 1999 amendment)	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal
Tennessee	1982	Yes (1997)	Group	Small employers of 50 or fewer or a premium increase of 1% or more	Substance use disorders	Mandated offering	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Tennessee	2000	Yes (1997)	Group	Small employers of 25 or fewer or a premium increase of 1% or more	Mental illness	Mandated benefits	20 days	25 visits	1 day of inpatient treatment can be converted to 2 days of partial/residential treatment	Must be equal	Must be equal
Texas	1981	No	Group and self-insured	Self-insured plans of 250 or fewer	Substance use disorders	Mandated benefit with a mandated offering for self-insured plans of 250 or fewer	Lifetime maximum of 3 separate series of treatments, including all levels of medically necessary care in each episode	Lifetime maximum of 3 separate series of treatments, including all levels of medically necessary care in each episode	Lifetime maximum of 3 separate series of treatments, including all levels of medically necessary care in each episode	Must be sufficient to provide appropriate care	Must be sufficient to provide appropriate care
Texas	1997	No	Group and HMO	Small employers of 50 or fewer	Serious mental illness	Mandated benefit with a mandated offering for small groups of 50 or less (law effective 1/1/04 allows insurers and HMOs to offer policies without this mandate)	45 days	60 visits; medication checks are not counted toward this limit	Not specified	Must be equal	Must be equal
Texas	2001	No	State employee plans		Serious mental illness	Minimum mandated benefit	45 days	60 visits	Not specified	Must be equal	Not specified; annual limits must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Utah	1994	No	Group		Substance use disorders	Mandated offering	Not specified	Not specified	Not specified	Not specified	Not specified
Utah	2001 (sunsets in 2011)	No	Group and HMO		Mental illness as defined by the DSM	Mandated offering	May include restrictions	May include restrictions	May include restrictions	May include restrictions	May include restrictions
Vermont	1998	No	Group, individual, and State employee plans		Mental illness including substance use disorders	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal to achieve the same outcome as treatment for any other illness
Virginia	2000 (2004 law deleted sunset provision)	No	Group and individual	Small employers of 25 or fewer	Biologically based mental illness, including substance use disorders	Parity	Must be equal to achieve the same outcome as treatment for any other illness	Must be equal to achieve the same outcome as treatment for any other illness	Must be equal to achieve the same outcome as treatment for any other illness	Must be equal to achieve the same outcome as treatment for any other illness	Must be equal to achieve the same outcome as treatment for any other illness
Virginia	Effective until 1/1/2000 and after 7/1/2004	No	Group, HMO, and individual		Mental illness and substance use disorders	Mandated benefits	25 days for adults and children	20 visits for adults and children	For children, up to 10 days of inpatient treatment can be converted at the rate of 1.5 days of partial treatment for 1 day of inpatient treatment	Coinsurance for insurance for outpatient treatment can be no more than 50% after 5 visits. All others must be equal	Benefits shall be no more restrictive than for other illnesses except as specified
Washington	1987	No	Group and HMO		Mental illness	Mandated offering	Not specified	Not specified	Not specified	Not specified	Not specified

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Washington	1988	No	Group		Substance use disorders	Mandated benefits	Not specified	Not specified	Not specified	Not specified	Not specified
West Virginia	1998	Yes (1997)	Group		Alcoholism	Mandated offering	30 days	Not specified	Not specified	Must be equal up to 30 days. Can not exceed 50% for outpatient	Not less than $750 annually and not less than an amount equal to the lesser of $10,000 or 25% of the lifetime limit
West Virginia	2002	Yes (1997)	State employee plans and group accident and sickness plans	State employee plan premium increase of 2% or more; group accident and sickness plans with a premium increase of 1% or more for plans of 25 or fewer and 2% or more for larger plans	Serious mental illness including substance use disorders	Parity	Must be equal	Must be equal	Must be equal	Must be equal	Must be equal

Continued

Table 3. Mental Illness and Substance Use Disorders Coverage Mandated by States, continued

State	Effective date	Adopted Federal parity	Affected populations	Exemptions to affected population	Illnesses covered	Type of mandated benefit	Scope of inpatient benefits in comparison with benefits for physical illnesses	Scope of outpatient benefits in comparison with benefits for physical illness	Scope of partial/residential benefits in comparison with benefits for physical illness	Copays and coinsurance in comparison with those for physical illness	Lifetime/annual dollar limits in comparison with those for physical illness
Wisconsin	2004	No	Group or blanket disability insurance		Mental illness and substance use disorders	Mandated offering	Except that the costs of prescription drugs and diagnostic tests are exempt from the limits set in the 1985 law, not fewer than the fewer of 30 days or $7,000 minus any cost sharing or, if the policy does not use cost sharing, $6,300 in equivalent benefits	Except that the costs of prescription drugs and diagnostic tests are exempt from the limits set in the 1985 law, not less than $2,000 minus any cost sharing or, if the policy does not use cost sharing, $1,800 in equivalent benefits	Except that the costs of prescription drugs and diagnostic tests are exempt from the limits set in the 1985 law, not less than $3,000 minus any applicable cost sharing for transitional treatment, or, if the policy does not use cost sharing, $2,700 in equivalent benefits	Except that the costs of prescription drugs and diagnostic tests are exempt, may apply the same deductible and/or copayment to behavioral health services that apply to all benefits. May apply deductibles, copays, or coinsurance to inpatient, outpatient, and transitional services	Except that the costs of prescription drugs and diagnostic tests are exempt, annual benefits need not exceed $7,000 or the equivalent benefits measured in services rendered. The amount may be reduced if the policy is written in combination with major medical coverage
Wyoming	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A

C. Exemptions

States Grant Exemptions from Parity and Mandated Benefits

Like the Federal mental health parity statute, many States have placed certain restrictions on, or granted exemptions to, the mandated offering requirement. A common exemption is one granted to small employers (most frequently those with fewer than 50 employees). Table 4 identifies the triggering threshold for this exemption, which some States included in their original legislation and some elected to add later.

Table 4. Exemptions Based on Size of Employer

State	*Exemptions*
Alabama	Small employers of 50 or fewer
Alaska	Employers with 5 or fewer employees
Arizona	Small employers of 50 or fewer
Arkansas	Small employers of 50 or fewer
Colorado	Employers of 50 or fewer purchase plans without mandate
Hawaii	Employers of 25 or fewer
Illinois	Employers of 50 or fewer
Kentucky	Small employers of 51 or fewer
Louisiana	Small employers
Maine	Small employers of 20 or fewer
Montana	Small group (unspecified number)
Nebraska	Small employers of 15 or fewer
Nevada	Small employers of 25 or fewer
Oklahoma	Small employers of 50 or fewer
Pennsylvania	Small employers of 50 or fewer
Tennessee	Small employers of 25 or fewer
Texas	Self-insured plans of 250 or fewer; small employers of 50 or fewer
Virginia	Small employers of 25 or fewer

Likewise, many States (13) have adopted clauses that waive the mandate (either mandated benefits or mandated offering) when the premium cost would increase if the benefit was added. A one percent rise in premium is typically the threshold for triggering the exemption. Table 5 describes, by State, the exemptions based on premium increases.

Table 5. Exemptions Based on Premium Increases

State	*Exemptions*
Arizona	Premium increase of 1 percent or more
Arkansas	Premium increase of 1 percent or more
Indiana	Premium increase of 4 percent or more
Louisiana	Premium increase of 1 percent or more
Michigan	Premium increase by 3 percent or more allows exemption from substance use disorders coverage
Mississippi	Premium increase of 1 percent or more
Montana	Premium increase of 1 percent or more
Nevada	Premium increase of 2 percent or more
New Mexico	Premium increase of more than 1.5 percent (more than 2.5 percent for employers of more than 50)
Oklahoma	Premium increase of 2 percent or more
South Carolina	Premium increase of 1 percent by 12/31/04 or 3.39 percent at any time between 01/01/02 and 12/31/04
Tennessee	Premium increase of 1 percent or more
West Virginia	Premium increase of 2 percent or more for State plans, 1 percent of more for group plans, 1 percent or more for plans of 25 or fewer employees, and 2 percent or more for larger plans

D. Mental Illness and Substance Use Disorders

States Differentiate Between Coverage for Mental Illness and Substance Use Disorders

Of the 32 States that mandate some coverage of behavioral health conditions, 22 require equal treatment for mental illness, defined as either biologically based mental illness or serious mental illness. In addition, other jurisdictions have chosen to require minimum benefits for mental illness and/or substance use disorders. However, most of these laws do not require equal treatment for all mental illness and substance use disorders.

Specifically, not only are substance use disorders treated differently than physical illness, but coverage of the diagnosis is required less often than for mental illness. Only 9 States have adopted parity statutes for substance use conditions, while 18 have chosen mandated offering provisions. Twenty States require a minimum benefit for substance use disorders, with some States singling out alcoholism as the condition for coverage.

Table 6 lists the 32 States that require some coverage of mental health conditions, also described as mental health parity or mandated minimum mental health benefits. Table 7 depicts the same findings for substance use disorders in 29 States.

Table 6. States Requiring Parity or Mandating Minimum Benefits—Mental Health

State	*Condition*	*Requirement*
Arkansas	Mental illness and developmental disorders	Parity for mental illness and developmental disorders
Arkansas	Mental illness	Parity
California	Severe mental illness	Parity
Colorado	Biologically based mental illness	Parity
Connecticut	Mental and nervous conditions	Parity
Delaware	Serious mental illness	Parity
Hawaii	Serious mental illness	Parity
Illinois	Serious mental illness	Parity for serious mental illnesses
Kansas	Mental illness	Mandated benefits
Kansas	Nervous/mental conditions	Mandated benefits
Louisiana	Serious mental illness	Mandated benefits
Maine	Mental illness; expands coverage to 11 categories of mental illness	Parity
Maryland	Mental illness, emotional disorders, residential crisis services defined as intensive mental health and support services	Minimum mandated benefit (statutory language; insurer can provide no less)
Massachusetts	Biologically based mental illness and related cases; all DSM diagnoses not covered under parity provisions	Parity for biologically based illnesses, mandated benefits for other DSM diagnoses

Continued

Table 6. States Requiring Parity or Mandating Minimum Benefits—Mental Health, continued

State	*Condition*	*Requirement*
Michigan	Mental health	Minimum mandated benefit
Minnesota	Mental illness	Parity for HMOs
Mississippi	Mental illness	Minimum mandated benefits for employers of more than 100
Montana	Severe mental illness	Parity
Montana	Mental illness	Mandated benefits
Nevada	Severe mental illness	Mandated benefits
New Hampshire	Mental illness	Parity for biologically based mental illness; minimum mandated benefits for other mental illnesses
New Jersey	Biologically based mental illness (group, individual, and State employee plan)	Parity
New Mexico	Mental health benefits as described in the group health plan	Parity
North Carolina	Mental illness	Parity
Oklahoma	Severe mental illness	Parity
Oregon	Mental illness	Mandated benefit
Pennsylvania	Serious mental illness	Mandated benefit
Rhode Island	Serious mental illness	Parity
Rhode Island	Mental illness	Minimum mandated benefit
South Carolina	Mental illness	Parity
South Dakota	Biologically based mental illness	Parity
Tennessee	Mental illness	Mandated benefits
Texas	Serious mental illness	Mandated benefit with a mandated offering for small groups of 50 or fewer (law effective 1/1/04 allows insurers and HMOs to offer policies without this mandate)
Texas	Serious mental illness	Minimum mandated benefit
Vermont	Mental illness	Parity
Virginia	Mental illness	Mandated benefits
West Virginia	Serious mental illness	Parity

Table 7. States Requiring Parity or Mandating Minimum Benefits—Substance Use Disorders

State	*Condition*	*Requirement*
Arkansas	Substance use disorders	Mandated offering for substance use disorders
Colorado	Biologically based mental illnesses (SA)	Parity
Connecticut	Substance use disorders	Parity
Delaware	Substance use disorders	Parity
Hawaii	Substance use disorders	Mandated benefits
Illinois	Alcoholism	Mandated benefit
Kansas	Substance use disorders	Mandated benefits
Kansas	Substance use disorders	Mandated benefits
Maine	Substance use disorders	Parity
Maryland	Substance use disorders; residential crisis services defined as intensive mental health and support services	Minimum mandated benefit (statutory language; insurer can provide no less)
Massachusetts	Substance use disorders	Parity for biologically based illnesses, mandated benefits for other DSM diagnoses
Michigan	Substance use disorders	Minimum mandated benefit
Minnesota	Substance use disorders	Parity for HMOs
Mississippi	Alcoholism	Mandated benefit
Montana	Substance use disorders	Mandated benefits
Nevada	Substance use disorders	Mandated benefits
New Hampshire	Substance use disorders and alcoholism	Minimum mandated benefits
New Jersey	Alcoholism (group and individual)	Mandated benefit for care prescribed by a doctor
North Carolina	Substance use disorders	Parity
North Dakota	Substance use disorders	Mandated benefit
Ohio	Alcoholism	Mandated benefit
Oregon	Substance use disorders	Mandated benefit
Pennsylvania	Substance use disorders	Mandated benefit
Rhode Island	Substance use disorders	Minimum mandated benefit
South Carolina	Substance use disorders	Parity
Texas	Substance use disorders	Mandated benefit with a mandated offering for self-insured plans of 250 or fewer employees
Vermont	Substance use disorders	Parity
Virginia	Substance use disorders	Mandated benefits
Washington	Substance use disorders	Mandated benefits
West Virginia	Substance use disorders	Parity

IV. State Laws

A. State Standards for Mental Health Workers

Through law and regulation, States govern health professions, specifying what procedures and functions are legally within the purview of members of an individual profession. Generally regarded as "scope of practice," these statutes and rules define the required educational and training preparation, and the procedures that can be administered and by whom, including what, if any, tasks can be delegated with supervision. In the eyes of the States, licensing is done only to protect the public from harm—not to ensure reimbursement or recognition.

Most States require professional and nonprofessional mental health employees to meet certain standards to be legally allowed to provide clinical services to clients. The most commonly recognized mental health professionals are psychiatrists, psychologists, psychiatric nurses, social workers, professional counselors, and marriage and family therapists (MFTs). States can establish either a licensing process, in which licensure is established through law and regulation to protect the public (e.g., through disciplinary measures) and define the scope of practice; or a certifying process, in which certification, awarded by a nongovernmental entity, is recognized by the State.

All 50 States have legal regulations governing psychiatrists, psychologists, psychiatric nurses, and social workers. For instance, social workers in Utah and Wyoming can choose to be recognized either by licensure or certification. Professional counselors can receive licenses in all jurisdictions, but Arkansas, California, Nevada, and Washington statutes include variations in the titles that are recognized.

MFTs are licensed in every State except North Dakota, West Virginia, Delaware, and Montana. In four States (Indiana,[3] Iowa,[4] Massachusetts,[5] and Washington[6]), MFT licensure is also extended to "mental health counselors." This category is identified as "mental health worker" in Wyoming, which codifies certification instead of licensure. MFTs have graduate training (a master's or doctoral degree) in marriage and family therapy and at least 2 years of clinical experience. According to the Web site of the American Association of Marriage and Family Therapists, MFTs treat the full range of mental and emotional disorders and health problems, including adolescent drug abuse, depression, alcoholism, obesity, and dementia in the elderly, as well as marital distress and conflict. Marriage and family therapists are licensed or certified in 46 States, but whether the practice scope includes substance use disorders counseling is determined by each State.

Nurses are licensed in all 50 States and in the District of Columbia. Many States require certification for an advanced practice license. Certification for psychiatric nurses, at all levels, is provided by the American

Nurses Credentialing Center (http://www.nursingworld.org/ancc/).

Advanced practice registered nurses (APRNs) hold a master's degree in psychiatric-mental health nursing (PMHN). PMHN is considered a specialty in nursing. In many States, APRNs have the authority to prescribe medications.

B. State Standards for Addiction Treatment Workers

A range of professionals may provide services to individuals with substance use disorders, including licensed physicians, nurses, psychologists, counselors, and clinical social workers. The addiction treatment worker classification most frequently recognized in State law or regulation include addiction counselors, alcohol and drug counselors, behavioral health counselors, certified therapeutic counselors, drug and alcohol abuse counselors, drug addiction counselors, drug addiction and addiction treatment counselors, drug treatment counselors, chemical dependency counselors, substance use disorders counselors, alcohol and drug counselors, addiction treatment professionals or counselors, and rehabilitation counselors. For the purpose of this report, all the above titles are considered acceptable derivatives of the addiction treatment professional known as the addiction treatment counselor. Fewer States elect to license workers in the substance use disorders field than in the mental health field, and certification is more common.

The determinations of professional and occupational eligibility to provide services are made on a State-by-State basis. Most States require, through statute or more commonly, regulation, alcohol and drug professionals to meet certain competency standards to provide clinical services. While most States have chosen certification, an increasing trend is to license counselors. In some States, certification is a voluntary process and persons are allowed to practice as substance abuse counselors without it. Often, substance abuse counselors work in agencies that are themselves licensed by the State, so this facility license may provide similar protections for the public. Moreover, certification can be a function of a State board or an outside nongovernmental entity, such as a professional association or certification body. The certification boards, whether State or nongovernmental, are authorized to examine and certify all drug and alcohol counselors and professionals for entry into the alcohol and drug counseling profession; provide professional competency standards that promote excellence in care, appropriate education, and clinical training of counselors; and assist counselors in providing quality treatment services.

For a comprehensive analysis of certification standards for counselors and prevention professionals, see a publication released in January 2005 by SAMHSA entitled *A National Review of State Alcohol and Drug Treatment Programs and Certification Standards for Counselors and Prevention Professionals*. Available at http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17024, it lists the relevant regulatory board in each State and the myriad certifications recognized as well as other requirements, including, for example, supervision, exam requirements, adherence to a code of ethics, and requirements for recertification. Additional information on specific standards and requirements for individual States can be accessed at http://www.nattc.org, the Web site of the Addiction Technology Transfer Center. Select the "Certification info" tab to search by State, territory, country organization, or keyword.

V. Analysis of Prescriptive Authority in the States

Only four professions are currently authorized to prescribe drugs for patients with behavioral health problems: physicians (including psychiatrists), psychologists, advanced practice nurses, and physician assistants.

A. Psychiatrists and Psychologists

Psychiatrists, who are physicians licensed to practice medicine in all its branches, are recognized by every jurisdiction, and the psychiatric scope of practice includes full prescriptive authority. In contrast, psychologists have not traditionally prescribed drugs, but the profession has recently embarked upon a legislative campaign throughout the country in pursuit of prescriptive authority. As of 2005, Louisiana and New Mexico were the only States to enact such statutes.

B. Advanced Practice Nurses and Physician Assistants

Nurse practitioners (NPs) and Physician Assistants (PAs) were first granted prescriptive authority in 1969. Virtually all States allow both entities prescribing privileges. (Hooker and Cipher, 2005). By 2006, NPs could prescribe in all 50 states plus the District of Columbia and independently of physicians in at least 14 states. NPs may prescribe controlled substances in 14 jurisdictions, with some degree of physician involvement in 33 other states. In 4 states, their prescriptive privileges exclude controlled substances. (Phillips, 2006).

Advanced practice nurses, who hold master's degrees, also have broad prescriptive authority throughout the United States, and the profession is recognized in State licensing laws by numerous titles, all describing or requiring generally the same level of competence.

For example, as illustrated in Table 8, 14 different advanced nursing practice titles are recognized by States for the same level of professional practitioner. Often umbrella titles such as advanced practice registered nurse (APRN) or advanced registered nurse practitioner (ARNP) are used in nurse practice acts to signify all categories of advanced practice providers who have prescriptive authority (e.g., nurse practitioner (NP), clinical nurse specialist (CNS)). Other variations include certified registered nurse practitioner (CRNP), certified clinical nurse specialist (CCNS), psychiatric-mental health clinical nurse specialist (PMHCNS), and registered nurse practitioner (RNP).

Table 8. Advanced Practice Titles

Abbreviation	Title
ANP	Advanced nurse practitioner
APNP	Advanced practice nurse practitioner
APPN	Advanced practice professional nurse
APN	Advanced practice nurse
APRN	Advanced practice registered nurse
ARNP	Advanced registered nurse practitioner
CNP	Certified nurse practitioner
CNS	Clinical nurse specialist
CCNS	Certified clinical nurse specialist
CRNP	Certified registered nurse practitioner
NP	Nurse practitioner
RNP	Registered nurse practitioner
PMHCNS	Psychiatric-mental health clinical nurse specialist
PMHCNP	Psychiatric-mental health clinical nurse practitioner

In positions advanced by the American Psychiatric Nurses Association (APNA), the American Nurses Association (ANA), and the Society for Education and Research in Psychiatric-Mental Health Nursing, as well as others (Bjorklund, 2003; Delaney, Chisholm, Clement, & Merwin, 1999; Moller & Haber, 2002; Naegle & Krainovich-Miller, 2001), the advanced practice role in the psychiatric-mental health (PMH) nursing specialty increasingly reflects a set of core competencies with little differentiation between the role competencies of NPs and CNSs. Because of the decentralized nature of the State Boards of Nursing and the authority vested in each board to develop and enact nurse practice statutes, rules, and regulations related to their State, wide variations still exist from State to State with regard to titling, prescriptive authority, and requirements for obtaining and renewing prescriptive authority.

Kaas and colleagues (2002) noted that a major problem posed by having so many different titles to signify advanced practice psychiatric-mental health nursing status is the confusion this generates in consumers, policy makers, legislators, other health providers, and third-party payers, who are unable to readily identify the advanced practice "brand" of their provider.

The type of prescriptive authority States grant to advanced practice nurses can be qualified as supervisory, collaborative, or independent prescriptive authority. Currently, only collaborative authority, used by 33 States, and independent prescriptive authority, by 16 States are employed. In Louisiana, for example, collaborative authority is granted to the APRN, which means a cooperative working relationship is established with a licensed physician to jointly contribute to providing patient care, which may include but is not limited to discussion of a patient's diagnosis and cooperation in the management and delivery of health care. The Louisiana statute goes on to define "collaborative practice" as "the joint management of the health care of a patient by an advanced practice registered nurse performing advanced practice registered nursing and one or more consulting physicians or dentists.… Acts of medical diagnosis and prescription by an advanced practice registered nurse shall be in accordance with a collaborative practice agreement," which is "a formal written statement addressing the parameters of the collaborative practice which are mutually agreed upon by the APRN and one or more licensed physicians or dentists which includes, but is not limited to, the physician availability."

As an example of independent prescriptive authority Iowa allows "advanced registered nurse practitioners (ARNPs) registered in Iowa in a recognized nursing specialty to prescribe, deliver, distribute, or dispense prescription drugs, devices, and medical gases when the nurse is engaged in the practice of that nursing specialty." Table 9 displays the

Table 9. Advanced Practice Nurses—Prescriptive Authority

State	*Title recognized*	*Prescriptive authority*	*National certification required*	*Type of authority: Independent (I) Collaborative (C) Supervised (S)*	*Notes*
Alabama	CRNP CNS	Yes	Yes	C	
Alaska	ANP*	Yes		I	*Certified CNSs from other States are eligible for certification as ANP
Arizona	RNP CNS	Yes No	No* Yes	I	*If applying after 7/1/04, certification required
Arkansas	APN includes - ANP - CNM - CNS - CRNA	 Yes Yes Yes Yes	Yes	 C C C C	
California	NP CNS*	Yes** No	No No	C	*Protected title requiring State certification **Must have a "furnishing" number from board of nursing and 6 months' physician supervision in furnishing drugs
Colorado	APN includes - NP - CNS	Yes	Yes	I	
Connecticut	APRN includes - NP - CNS - CNM - CRNA	Yes	Yes	C	
Delaware	APN	Yes	Yes	I	Need written plan with physician for consultation and referral
District of Columbia	NP CNS	Yes Yes	* 	I I	*Not specified
Florida	ARNP includes - NP - CNS*	Yes	Yes	C**	*CNS is not recognized but may apply for licensure as ARNP. **Protocols established between ARNP and physician with separate written contract
Georgia	APRN includes - NP - CNS-PMH	No*	Yes		*May not prescribe, but APRN may be delegated by physician under protocols to "order"
Hawaii	APRN includes - NP - CNS - CNM - CRNA	Yes	Yes	*	* - 1000 hours of clinical experience as APRN in specialty - Must have written collegial relationship with physician - Physician's name must appear on prescriptions

Continued

Table 9. Advanced Practice Nurses—Prescriptive Authority, continued

State	*Title recognized*	*Prescriptive authority*	*National certification required*	*Type of authority: Independent (I) Collaborative (C) Supervised (S)*	*Notes*
Idaho	APPN includes - CNS - NP - CNM - RNA	Yes	 Yes Yes Yes Yes	C	
Illinois	APN includes - CNP - CCNS - CNM - CRNA	Yes	 Yes Yes Yes Yes	C	
Indiana	NP CNS CNM	Yes Yes Yes		C** C** C**	**No collaborative agreement is necessary unless prescriptive authority is sought.
Iowa	ARNP includes - NP - CNS - CNM - CRNA	Yes	Yes	I	
Kansas	ARNP includes - NP - CNS - NM - NA	Yes	Yes	C	
Kentucky	ARNP (CS*)	Yes	Yes	C	*A clinical specialist practicing as an APRN is required to register as ARNP.
Louisiana	APRN includes - CNM - CRNA - CNS - NP	Yes	Yes	C	
Maine	APRN includes - CNP - CNM - CRNA - CNS	 Yes* Yes* No No	Yes**	I	*Restricted formulary **APRNs approved before 1/1/96 are considered to have met education and certification requirements.
Maryland	APRN includes - NP - APRN/PMH - Nurse Psycho-therapist*	 Yes No	 Yes Yes	 C I	*Protected title
Massachusetts	NM NP PMH-CNS RNA	Yes Yes Yes Yes	Yes Yes Yes Yes	C C C S	

Continued

Table 9. Advanced Practice Nurses—Prescriptive Authority, continued

State	Title recognized	Prescriptive authority	National certification required	Type of authority: Independent (I) Collaborative (C) Supervised (S)	Notes
Michigan	NP NM RNA	Yes	Yes Yes Yes	C	
Minnesota	CNP CNM CNS-PMH CNS CRNA	Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes	C C C C C	
Mississippi	CNS NP includes - NP - CNM - RNA	No Yes		C	
Missouri	APN includes - NP - CNM - CRNA	Yes	Yes*	C	*Identifies specific certifying boards
Montana	APRN	Yes	Yes	I*	*Must have a "quality assurance" plan that requires quarterly review by physician and peers
Nebraska	APRN includes - NP - CNS	Yes	Yes	C	
Nevada	APN* includes - NM - Nurse Psycho-therapist - NP - CNS	Yes*	No**	C	*Prescriptive Privileges require 1000 hours' practice, pharmacology education, and collaborating physician attestation of competency. **Certification required in absence of more common requirements
New Hampshire	ARNP includes - CNM - CRNA - NP - PMH-CNS	Yes*	Yes	I	*Restricted formulary
New Jersey	APN includes - NP - CNS	Yes	Yes	C	
New Mexico	CNP CNS	Yes Yes	Yes* Yes		*NPs licensed before 12/85 are not required to have national certification.
New York	NP CNS*	Yes No	No	C	*Not a recognized title
North Carolina	NP	Yes	Yes	C	

Continued

Table 9. Advanced Practice Nurses—Prescriptive Authority, continued

State	Title recognized	Prescriptive authority	National certification required	Type of authority: Independent (I) Collaborative (C) Supervised (S)	Notes
North Dakota	NP CNS	Yes Yes	Yes Yes	C C	
Ohio	NP CNS	Yes Yes	Yes	C C	
Oklahoma	ARNP includes - NP - CNS	Yes	Yes	C	
Oregon	NP CNS	Yes No		I	
Pennsylvania	CRNP includes - NP - CNS	 Yes No	Yes	 C	
Rhode Island	CRNP CNS P-MH	Yes Yes	Yes Yes	C C	
South Carolina	APRN includes - NP - CNS	Yes	Yes	C	
South Dakota	NP CNS	Yes No		C	
Tennessee	CNP	Yes	Yes	C	
Texas	NP CNS	Yes Yes	Yes	C C	
Utah	APRN	Yes	Yes	I*	*When prescribing schedule II and III drugs, must have written collegial relationship and a consultation and referral plan
Vermont	APRN	Yes	Yes	I	
Virginia	LNP CNS	Yes No	Yes Yes	C I	
Washington	ARNP	Yes	Yes	I	
West Virginia	ANP	Yes	Yes	C	
Wisconsin	APNP includes - NP - CNS	Yes	Yes	I	
Wyoming	APN includes - NP - CNS	Yes	Yes	I*	*Must have plan for physician referral and plan of coverage

Source: Haber et al. (2003).

States that grant prescriptive authority and the type of authority granted, and those that have elected to require forms of national certification (in addition to licensure) as a qualification for prescriptive authority.

Physician assistants are health care professionals licensed, or in the case of those employed by the Federal government they are credentialed, to practice medicine with physician supervision. They are defined by State law, and certain educational requirements apply. PAs' education in general requires a 26-month training beyond achieving certain prerequisites to enter a program; it varies by State licensing requirements. The prerequisites are equivalent to about 3 years of undergraduate work, but most persons entering PA training have a bachelors degree and some experience in health care. To become licensed or certified, a clinical clerkship as well as passing a national exam is required; to practice, continuing hours training and recertification every 6 years is required.

PAs may conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions. Within the physician-PA relationship, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. PA prescriptive authority is always dependent on delegation by a supervising physician who need not necessarily be present. Table 10 illustrates that PAs may prescribe in all 50 States, the District of Columbia, and Guam. In ten States, they are restricted to a formulary; in five States they may not prescribe any controlled substances.

Table 10. Where Physician Assistants Are Authorized To Prescribe

Jurisdiction	*Rx Status*	*Restrictions*	*Controlled Substances*
Alabama	Rx	Formulary	
Alaska	Rx		Sch. III-V
Arizona	Rx		Sch. II-III limited to 14-day supply with board prescribing certification (72-hrs. without); Sch.IV-V not more than 5 times in 6-month period per patient
Arkansas	Rx		Sch. III-V
California	Rx	PAs may write "drug orders" which, for the purposes of DEA registration, meet the federal definition of a prescription.	Sch. II-V*
Colorado	Rx		Sch. II-V
Connecticut	Rx		Sch. II-V
Delaware	Rx		Sch. II-V
District of Columbia	Rx		

Continued

Table 10. Where Physician Assistants Are Authorized To Prescribe, continued

Jurisdiction	*Rx Status*	*Restrictions*	*Controlled Substances*
Florida	Rx	Formulary of prohibited drugs	
Georgia	Rx	Formulary	Sch. III-V
Guam	Rx		Sch. III-V
Hawaii	Rx		Sch. III-V
Idaho	Rx		Sch. II-V
Illinois	Rx		Sch. III-V
Indiana	Rx**		Sch. III-V
Iowa	Rx		Sch. III-V; Sch. II (except depressants)
Kansas	Rx		Sch. II-V
Kentucky	Rx		
Louisiana	Rx		Sch. III-V
Maine	Rx		Sch. III-V (Board may approve Sch.II for individual PAs)
Maryland	Rx		Sch. II-V
Massachusetts	Rx		Sch. II-V
Michigan	Rx		Sch. III-V; Sch. II (7-day supply) as discharge meds
Minnesota	Rx	Formulary	Sch. II-V
Mississippi	Rx		Sch. II-V
Missouri	Rx		
Montana	Rx		Sch. II-V (Sch. II limited to 34-day supply)
Nebraska	Rx		Sch. II-V
Nevada	Rx		Sch. II-V
New Hampshire	Rx		Sch. II-V
New Jersey	Rx		Sch. II-V (certain conditions apply)
New Mexico	Rx	Formulary	Sch. II-V
New York	Rx		Sch. III-V
North Carolina	Rx		Sch. II-V (Sch. II-III limited to 30-day supply)
North Dakota	Rx		Sch. III-V
Ohio	Rx***		Sch. III-V
Oklahoma	Rx	Formulary	Sch. III-V (limited to 30-day supply)
Oregon	Rx		Sch. II-V
Pennsylvania	Rx	Formulary	Sch. II-V. (Sch. II limited to 72 hours for initial therapy; 30 days for ongoing therapy. Sch. III-V limited to 30-day supply unless for chronic condition.)

Continued

Table 10. Where Physician Assistants Are Authorized To Prescribe, continued

Jurisdiction	*Rx Status*	*Restrictions*	*Controlled Substances*
Rhode Island	Rx		Sch. II-V
South Carolina	Rx	Formulary	Sch. III-V
South Dakota	Rx		Sch. II-V (Sch. II limited to 30-day supply)
Tennessee	Rx		Sch. II-V
Texas	Rx	In specified practice sites	Sch. III-V (limited to 30-day supply)
Utah	Rx		Sch. II-V
Vermont	Rx	Formulary	Sch. II-V
Virginia	Rx		Sch. III-V (authorization for Sch. II prescribing begins 7/1/07
Washington	Rx		Sch. II-V
West Virginia	Rx	Formulary	Sch. III-V (Sch. III limited to 72-hr supply)
Wisconsin	Rx		Sch. II-V
Wyoming	Rx		Sch. II-V

5/10/07

DEA Registration
The Drug Enforcement Administration (DEA) has a registration category specifically for physician assistants and other so-called "midlevel practitioners" authorized by state law or regulation to prescribe controlled substances. For more information or to obtain a registration application, contact the DEA Registration Unit at 800/882-9539. Additional information on DEA registration can be found at *www.aapa.org/gandp/issuebrief/DEA.htm*.

* Controlled medications require a patient-specific order from the supervising physician.

** Statute authorizing delegated prescribing was passed in the 2007 legislative session, but regulations to implement prescriptive authority have not yet been adopted.

*** Statute authorizing delegated prescribing became effective 5/14/06, but regulations to implement prescriptive authority have not yet been adopted.

This table is used with the permission of the American Academy of Physician Assistants and can be viewed at: http://www.aapa.org/gandp/rxchart.html.

C. State Actions on Psychotropic Drugs in Schools

An emerging issue related to prescribing authority is directed toward children and psychotropic medications. These drugs often are used in the treatment of children with attention deficit/hyperactivity disorder (ADHD), a condition that is being diagnosed with increasing frequency.

Some teachers and education officials have advocated for laws (or school policy) requiring afflicted students to take prescribed medication as a condition for participation in school activities. In reaction, a legislative backlash has begun in recent years as States have attempted to curtail these requirements. Three States (Colorado, Connecticut, and Texas) have passed laws prohibiting these policies and specifically forbidding school personnel from requiring or recommending prescriptive medication to students. Table 11 describes the recent State legislative activity addressing this issue.

Table 11. Psychotropic Drugs—Prohibitions on School Employees

State	*Not permitted to require or recommend drugs*	*Not permitted to limit access to school or activities*	*Other*
California			Legislation passed encouraging the Federal government to study the use of psychotropic drugs to treat children #### Only a juvenile court judicial officer shall have authority to make orders regarding the administration of psychotropic medications for a child removed from the physical custody of the parent.
Colorado	X		
Connecticut	X		Refusal of a parent or guardian to administer or consent to the administration of any psychotropic drug to such child shall not, by itself, constitute grounds for the Department of Children and Families to take such child into custody.
Illinois			Psychotropic medication shall not be prescribed without the informed consent of the resident or the resident's guardian.
Massachusetts			Health Department to promulgate regulations governing the administration of psychotropic medications to children in school settings
New Hampshire			Refusal of a parent to administer or consent to the administration of any psychotropic drug shall not, by itself, constitute grounds for the police to take the child into custody.
Oregon			Adopted procedures for use of psychotropic medications for children in foster care
South Dakota			Delineates the procedure for petitioning the circuit court for the authority to administer psychotropic medication to an involuntarily committed patient
Texas	X	X	Refusal of a parent or guardian to administer or consent to the administration of a psychotropic drug to the child does not by itself constitute neglect. #### An employee of a school district may not use or threaten to use the refusal of a parent or guardian of a child to administer or consent to the administration of a psychotropic drug to the child as the sole basis for making a report of neglect of the child.

VI. Conclusion

This report reviewed the current state mandates and trends regarding benefits, coverage, prescriptive authorities and parity. A brief summary follows.

1. State-mandated benefits for behavioral health care

Most States have enacted some relevant legislation, but concerns about rising health care costs have led State legislatures to scale back previously required benefits. With the cost of health care coverage an increasingly large portion of State and private sector budgets, there are few reasons to expect that this trend to scale back will not continue at least for the near-term future.

In general, State legislators enacted legislation to mandate insurance coverage for mental illness and substance use disorders approximately 20 years before the U.S. Congress. While the States initially focused on mandated offering and mandated benefits, over time, State legislators began to require parity between mental and physical health treatment. The current status of mental illness and substance use disorders legislation in the United States is a veritable patchwork. Nearly all States have enacted legislation requiring health insurance companies to provide some coverage—mandated offering, mandated benefits, or parity coverage—for mental illness and substance use disorders. Nevertheless, substance use disorders coverage continues to lag behind benefits for mental health treatment.

2. State laws regulating behavioral health care workers

States generally tend to license personnel in the mental health field and certify workers who provide substance use disorders treatment.

3. Analysis of State-recognized prescriptive authority for psychotropic drugs

Regarding personnel, the primary trend seems to be a State movement toward granting greater prescriptive authority for health care professionals, particularly psychologists. There are considerable concerns about the cost of prescriptions that could be impacted by the State recognizing more professionals with prescriptive authority.

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Notes

1. Many terms have been used to describe the addiction treatment profession. The current term accepted by most scientists and experts in the field is substance use disorders. For the purposes of this report, this term will be used throughout.

2. Indiana defines "mental health counseling" as "a specialty that (1) uses counseling and psychotherapeutic techniques based on principles, methods, and procedures of counseling that assist people in identifying and resolving personal, social, vocational, intrapersonal, and interpersonal concerns; (2) uses counseling to evaluate and treat emotional and mental problems and conditions in a variety of settings, including mental and physical health facilities, child and family service agencies, or private practice, and including the use of accepted evaluation classifications, including classifications from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as amended and supplemented, but only to the extent of the counselor's education, training, experience, and scope of practice as established by this article; (3) administers and interprets appraisal instruments that the mental health counselor is qualified to employ by virtue of the counselor's education, training, and experience; (4) uses information and community resources for personal, social, or vocational development; (5) uses individual and group techniques for facilitating problem solving, decision making, and behavioral change; (6) uses functional assessment and vocational planning guidance for persons requesting assistance in adjustment to a disability or disabling condition; (7) uses referrals for individuals who request counseling services; and (8) uses and interprets counseling research."

   "An individual who applies for a license as a mental health counselor must have a master's or doctoral degree in an area related to mental health counseling; completed specified educational and experience requirements; no record of having a conviction for a crime that has a direct bearing on the individual's ability to practice competently; not been the subject of a disciplinary action by a licensing or certification agency of another State or jurisdiction on the grounds that the individual was not able to practice as a mental health counselor without endangering the public; passed an examination provided by the board."

3. Iowa defines "mental health counseling" as the "provision of counseling services involving assessment, referral, consultation, and the application of counseling, human development principles, learning theory, group dynamics, and the etiology of maladjustment and dysfunctional behavior to individuals, families, and groups. An individual is eligible for licensure in Iowa as a mental health counselor when s/he possesses a master's degree in counseling consisting of at least 45 credit hours, or its equivalent, from a nationally accredited institution or from a program approved by the board; has at least 2 years of clinical experience, supervised by a licensee, in assessing mental health needs and problems and in providing appropriate mental health services as approved by the Board of Behavioral Science Examiners in consultation with the Mental Health and Developmental Disabilities Commission; and passes an examination administered by the Board."

4. Massachusetts defines the qualifications for mental health counselors in the same statute with marriage and family therapists, rehabilitation counselors, mental health

counselors, and educational psychologists who may be licensed upon providing "satisfactory evidence to the board that s/he (1) is of good moral character; (2) has not engaged or is not engaging in any practice or conduct that would be grounds for refusing to issue a license under section 169; (3) demonstrates to the board the successful completion of a master's degree in a relevant field from an educational institution licensed by the State in which it is located and meets national standards for granting of a master's degree with a subspecialization in marriage and family therapy, rehabilitation counseling, counseling, or a relevant subspecialization approved by the board. To be eligible for licensure, an applicant must have 2 additional years of supervised clinical experience in the relevant field in either a clinic or hospital licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or institute or under the direction of a supervisor approved by the board. For purposes of this clause, 'supervision' shall be defined as no fewer than 200 hours of supervised clinical experience, at least 100 hours of which shall consist of individual supervision with a clinician who has expertise in marriage and family therapy, rehabilitation counseling, educational psychology, or counseling, and who holds a master's degree in social work, marriage and family therapy, rehabilitation counseling, educational psychology, counseling, or an equivalent field, or holds a doctoral degree in psychology, or a medical degree with a subspecialization in psychiatry; and (4) successfully passes a written or oral examination administered by the board to determine the applicant's qualifications for licensure for each profession licensed pursuant to this section."

5. Washington State defines "counseling" as employing any therapeutic techniques, "including but not limited to social work, mental health counseling, marriage and family therapy, and hypnotherapy, for a fee that offer, assist, or attempt to assist an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential. For the purposes of this chapter, nothing may be construed to imply that the practice of hypnotherapy is necessarily limited to counseling."

Washington uses an omnibus credentialing act to "issue a registration to any applicant who submits, on forms provided by the secretary, the applicant's name, address, occupational title, name and location of business, and other information as determined by the secretary, including information necessary to determine whether there are grounds for denial of registration or issuance of a conditional registration under this chapter or chapter 18.130 RCW. Applicants for registration shall register as counselors or may register as hypnotherapists if employing hypnosis as a modality. Applicants shall, in addition, provide in their titles a description of their therapeutic orientation, discipline, theory, or technique. Each applicant shall pay a fee determined by the secretary as provided in RCW 43.70.50, which shall accompany the application."

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