Massachusetts Division of Insurance Mental Health Parity Summary Report For the Period of Calendar Year 2024

Acknowledgements

The enclosed report was prepared by the Massachusetts Division of Insurance ("Division"). It is being furnished to the Clerk of the Massachusetts Senate, the Clerk of the Massachusetts House of Representatives, the Joint Committee on Mental Health, Substance Use and Recovery, and the Joint Committee on Health Care Financing in accordance with M.G.L. c. 26, section 8M.

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Mental Health Parity Reports

This report represents the report of the Division of Insurance to present information regarding carriers' compliance with state and federal Mental Health Parity rules. According to section 8M(d) of M.G.L. 26, the report is to include the following:

(i) the methodology the commissioner is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act;

(ii) the methodology the commissioner is using to check for compliance with section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G;

(iii) the report of each market conduct examination conducted or completed during the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and any actions taken as a result of such market conduct examinations;

(iv) a breakdown of treatment authorization data for each carrier for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient services and total services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lower amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and (C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal was filed and upheld and outpatient service requests where an external appeal was filed and overturned;

(v) the number of consumer complaints received by the division of insurance under subsection (f) of section 8K in the immediately preceding calendar year and a summary of all such complaints resolved by the division during that time period, including: (A) the number of complaints resolved in favor of the consumer; (B) the number of complaints resolved in favor of the carrier; and
(C) any enforcement actions taken in response to such complaints; and

(vi) information about any educational or corrective actions the commissioner has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B and said section 4M of said chapter 176G.

Methodology to Check for Compliance with the Federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

One of the central features of MHPAEA is the requirement that carriers that are subject to MHPAEA cannot impose annual or lifetime dollar limits on mental health and substance use benefits that are less favorable than annual or lifetime dollar limits imposed on medical/surgical benefits.

Additionally, while financial treatment limits are permitted, the law requires that any financial treatment limits for mental health/substance use services are no more restrictive than the predominant financial treatment limits for substantially all medical or surgical services. Carriers are to show compliance with this requirement in the following service categories: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drugs. The Division reviews health carriers' evidences of coverage and schedules of benefit to ensure compliance with this requirement.

MHPAEA also requires that carriers employing utilization management by conducting utilization reviews through prior authorization or similar techniques, referred to as non-quantitative treatment limitations, or NQTLs, to conduct an annual comparative analysis to verify that the NQTLs applied to mental health and substance use services are not more restrictive than NQTLs applied to medical and surgical services.

As part of its review of federal MHPAEA requirements, the Division verifies that carriers' policies and procedures related to their use of NQTLs are in compliance both as written as well as in operation. Carriers are required to not only submit their NQTL analysis, but also to submit their policies and procedures. These are the underlying documents that describe how Carriers aim to carry out the functions pertaining to the utilization management features that are the subject of the NQTL analysis. In order to verify compliance with Carriers' Mental Health Parity requirements in operation, Carriers are to submit information that shows, e.g., claims analyses indicating that the number of claims paid among various service categories are comparable between mental health and substance use services and medical and surgical services; and information that shows that the formulary design includes medications that are not classified in tiers that cause medications for mental health/substance use benefits to generally be tiered at a higher cost tier than medical and surgical benefits.

Methodology to Check for Compliance with section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G

Section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G requires health insurance carriers to cover mental health benefits on a nondiscriminatory basis "for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM: (1) schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; (10) eating disorders; (11) post traumatic stress disorder; (12) substance abuse disorders; and (13) autism."

Central to verification of compliance with these state requirements, the Division reviews carriers' evidences of coverage to ensure that all required mental health benefits are included. The Division reviews carriers' evidences of coverage to ensure that there are no exclusions that may provide limitations of the required mental health benefits that result in these benefits being less favorable than medical/surgical benefits. The Division reviews carriers' schedules of benefit which describe any cost-sharing features part of each plan in order to identify whether any cost-sharing is less favorable for mental health/substance use services than for medical/surgical services. Similar to the review of federal requirements, the Division ensures that Carriers do not set any financial limits to their benefits that are more restrictive for mental health and substance use services than for medical and surgical services.

The Division's instructions (see Division Filing Guidance 2025-O) to Carriers for the 2024 Mental Health Parity Report, issued on May 2, 2025, consisted of the following requirements:

- Signed Certification of Compliance;
- Completed Federal Self-Compliance Tool;
- Confirmation of coverage of the following behavioral health services for children and adolescents required pursuant to Chapter 110 of the Acts of 2017:
    - Intensive care coordination for a child with serious emotional disturbances;
    - Mobile crisis intervention;
    - Family support and training;
    - In-home therapy;
    - Therapeutic mentoring services; and

    - In-home behavioral services (collective referred to as “Behavioral Health for Children and Adolescents” or “BHCA”); and
- Additional Massachusetts-specific information, including Prior Authorization Data, as outlined in Bulletin 2013-06 and subsequent annual request memoranda to Carriers.

In addition, the Filing Guidance consisted of the following items required to show compliance with M.G.L. c. 26, section 8M, as enacted by Chapter 177 of the Acts of 2022:

(i) the specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification; provided, however, that the nonquantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

In reviewing carriers’ responses for the specific plan or coverage terms, the Division looked for details pertaining to each of the NQTL categories that were the subject of the annual certification submissions – prior authorization; concurrent review; retrospective review; step-therapy; network admission standards; reimbursement rates; and geographic restrictions. The Division follows up with any carrier if plan or coverage terms are too general, if a carrier requires blanket prior authorizations for behavioral health or substance use services, or if utilization management procedures appear to be more restrictive for behavioral health or substance use services; has a different reimbursement rate structure for behavioral health or substance use services; or if a carrier’s policies indicate restrictions for behavioral health or substance use services based on geographic locations that are not in place for medical or surgical benefits.

(ii) the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

In reviewing Carriers’ responses for the factors used for each of the NQTL categories, the Division notes whether carriers not only apply the same factors for both medical/surgical benefits and mental health/substance use services but also ensure that carriers do not apply those factors in a more restrictive manner for mental health/substance use services. For example, while it is permissible for a carrier to identify recent medical cost escalation as a factor for deciding to apply prior authorization, the carrier has to provide evidence that both as written policy, and in actual operation, the carrier is not applying the factor more stringently for mental health/substance use services.

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

In reviewing Carriers' responses for any evidentiary standards used to apply NQTL factors, the Division requires that Carriers identify the sources of the evidentiary standards to ensure that Carriers use appropriate professional and generally accepted sources, such as medical experts and recognized treatment guidelines. Further, the Division reviews the identified evidentiary standards to ensure they are not being applied more restrictively for mental health/substance use services.

(iv) a comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical and surgical benefits in the benefits classification;

In reviewing Carriers' comparative analyses, the Division looks to identify any differences in definitions, factors, evidentiary standards or processes in applying them to medical/surgical benefits and mental health/substance use benefits. Further, the Division reviews whether there are differences in Carriers' internal staff who are reviewing the development and application of NQTLs. For example, Carriers are to identify which committees are responsible for the development of a particular NQTL, what level of experience the committee members have, and what areas of expertise they have. If a Carrier has contracted with another entity to perform mental health/substance use utilization management functions, the Carrier must explain any differences between the internal processes and those of the contracted entity. More importantly, as part of its comparative analysis, the Carrier must identify that the functions of the Carrier and any contracted entity have been analyzed in comparison to each other and not solely rely on each entity individually having followed Mental Health Parity requirements in the development of any NQTLs.

(v) the specific findings and conclusions reached by the carrier with respect to health insurance coverage, including any results of the analysis described in clause (iv) that indicate whether the carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3).

In reviewing this section, the Division identifies whether any Carrier – in certifying compliance with NQTL requirements – has made statements that are too general or vague in nature; has not provided information on specific committees involved in the development of NQTLs; is relying on outdated materials; or has provided an incomplete analysis.

None of the Carriers which submitted a 2024 Mental Health Parity Annual Report to the Division identified any areas of deficiency or any corrective actions arising from their own certification process.

All carriers were found to have submitted NQTL analyses for the following required NQTL categories, unless a Carrier does not apply any NQTLs for a given category:

Prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates and geographic restrictions.

A summary of each carrier's specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification is provided in Appendix C.

A summary of each carrier's factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits is provided in Appendix D.

A summary of each carrier's evidentiary standards used in applying the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits is provided in Appendix E.

Based on a review of the materials submitted and using the methodology described above, the Division did not find that any Carrier was not compliant with federal or state Mental Health Parity requirements.

Observations

While the Division's review did not find specific areas of non-compliance on the part of any individual Carrier, the following observations led the Division to follow up with Carriers to identify areas of clarification or opportunities for improvement of Carriers' NQTL responses or processes.

Differences in Definitions

The Division found that there were instances where definitions of certain terms were not identical in the application of NQTLs between Medical/Surgical benefits and Mental Health/Substance Use benefits. For example, if a Carrier has a definition for Evidentiary Standards when applied to Medical/Surgical benefits that differs from the definition when applied to Mental Health/Substance Use benefits, it may be unclear whether the Evidentiary Standards are being applied in a comparable manner. The Division followed up to ensure that these terms were being applied consistently.

Missing or Incomplete Information

The Division found that there were instances where (1) Carriers either did not specify either the position/title of all members of a utilization management committee, or their educational level; or (2) instances where this information was incomplete or missing in connection with specific utilization management functions (e.g., establishing rates of reimbursement for participating providers); or (3) instances where this information was missing or incomplete for members who participated in the comparative analysis. The Division followed up in these instances with Carriers to ask that they provide the missing or incomplete information.

As Written Analysis vs. In Operation Analysis

The Division found that there were instances where Carriers needed to supplement their responses to verify that their internal NQTL analysis showed compliance not only related to their policies and procedures as written, but also their policies and procedures in operation. The Division followed up with Carriers in instances where the Division found a lack of utilization review data that would reveal comparable outcomes in the rate of denials for the various NQTL categories.

Market Conduct Examinations

On August 10, 2023, the Division began behavioral health parity market conduct examinations of twenty-one (21) health insurance carriers to assess their compliance with behavioral health parity requirements under section 8K of Chapter 26 of the Massachusetts General Laws, as amended by Chapter 177 of the Acts of 2022 (An Act Addressing Barriers to Care for Mental Health), section 4 of Chapter 175, section 10 of Chapter 176G, and all other applicable laws. To support this effort, the Division engaged the INS Companies, an approved vendor under RFR-2018-DOI-002 – Market Conduct Examination Services. The scope of the examinations evaluated insurers' compliance with relevant provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MPHEA"), as amended, and with any federal guidance or regulations related to the act, including 45 CFR Parts 146.136, 147.136, 147.160, and 156.115(a)(3). The examination scope also covered applicable state mental health parity laws, including, but not limited to, Section 47B of Chapter 175, Section 8A of Chapter 176A, Section 4A of Chapter 176B, and Sections 4, 4B, and 4M of Chapter 176G.

The examinations followed the directives outlined in federal and state legislative mandates. They employed a tailored methodology that utilized standards outlined in the 2022 NAIC Market Regulation Handbook (the "Handbook"), as well as applicable Commonwealth of Massachusetts insurance laws, regulations, and relevant federal legislation. The Division initiated the examination process with an Interrogatory, one of the review methods under the Continuum of Regulatory Options ("Continuum") for Market Conduct Examinations as provided in the Handbook. Examiners focused on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA, and denials of payment and coverage. Additionally, the examiners reviewed corrective actions implemented in response to previous examinations or reviews by other regulators or law enforcement agencies, including the Massachusetts Attorney General's Office.

As of the issuance of this report, the Division has conducted 21 examinations across 13 insurer groups. Of these, 20 examinations were completed as of December 8, 2025, with the remaining examination completed on May 15, 2026. Reports for all completed examinations are available on the Division's website at Division Market Conduct Examination Reports. The examinations included domestic, regional, and national companies subject to MHPAEA. This review was a high-level assessment focusing primarily on processes, procedures, and aggregate data. The Division anticipates that future examinations will cover topics such as claims, NQTL comparative analysis, third-party administrator auditing, and the use of artificial intelligence by health insurers.

In assessing insurance carriers' overall compliance with mental health parity standards, it was clear that Massachusetts insurers are committed to meeting, and where possible exceeding, the state and federal standards. Upon reviewing the examination results, both the Division and the subject insurers collaborated to ensure that the evaluations accurately reflect the current compliance status with behavioral health parity requirements. The examinations, which began in 2023 by evaluating mental health parity compliance in 2022, ultimately highlight the notable progress made in developing and implementing policies and procedures to ensure MHPAEA compliance through the efforts

of insurance carriers and regulators.

In assessing network adequacy, the examination process revealed the positive impact of the Commonwealth's commitment to removing stigmatizing questions about mental health history from the clinician credentialing process. Furthermore, the review and discussions with insurance carriers demonstrated their efforts to increase the number of credentialed providers available to members for treatment and services. Additionally, the Massachusetts Physician Credentialing Initiative establishes a standardized process for physician credentialing by health plans and hospitals. This effort simplifies and unifies the credentialing process, providing a single application that physicians can complete, copy, and submit to each health plan and hospital they wish to affiliate with. Participating health plans aim to process 95% of initial applications within 30 days and will regularly update physicians on the status of their applications. The examiners found that most insurance carriers were meeting this processing goal. Physicians credentialed through this process will be authorized to treat plan enrollees and will be reimbursed by the applicable health insurance plan for covered services starting from the plan's credentialing date.

One initiative that has helped insurance carriers meet new state and federal regulations requiring more frequent attestation of directory data and ensuring network adequacy is the Massachusetts Council for Affordable Quality Healthcare ("CAQH") DirectAssure program, developed by the CAQH. This application enables providers to update their information in a single, central location. The application uses the existing CAQH ProView database to streamline the process. Providers are asked to verify their practice location, accepted insurance plans, and whether they are accepting new patients – all essential information for members and consumers searching for a new or additional provider.

In 2023, the Division of Insurance introduced revised market conduct reporting requirements for insurance carriers to incorporate into their procedures, alongside existing financial and other reporting obligations. Through analyzing examination data submissions and discussing with insurers, the examiners found that insurance carriers were implementing the updated records and tracking systems and making adjustments to ensure compliance with the new requirements. Thanks to the Division's strong guidance and oversight efforts, the implementation of these requirements appeared to proceed smoothly.

In 2020, the Massachusetts Attorney General examined several health insurance carriers to evaluate their compliance with the then-current behavioral health regulatory requirements. For those health insurers included in the Division's examination, the examiners reviewed the insurer's compliance with the recommendations of the earlier Attorney General's report. The insurance carriers' practices comply with the corrective actions detailed in the reports.

Many insurance carriers use third-party administrators to carry out specific processes and services to comply with federal and state laws. As reliance on these contracted entities has increased, however, the potential drawbacks of using these vendors without proper oversight have emerged during examinations and have been noted by the examiners. Indeed, third-party vendors may help insurance carriers meet service objectives, but insurance carriers must carefully assess third-party vendor practices and procedures to ensure these comply with all regulatory requirements. To ensure that services provided by third-party vendors comply with MHPAEA requirements, insurance carriers must review third-party vendor practices before engaging them and implement routine monitoring and quality assurance procedures. The insurance carriers ultimately are responsible for providing members with services that comply with all regulatory mandates, including those governing MHPAEA requirements. Examiners found that, overall, companies were in varying degrees of compliance concerning supervision of contracted vendors and that regular updates and routine audits, such as those required upon the enactment of new or amended laws and regulations, were not consistently conducted. Similarly, when reviewing health care claims handling, many companies did not initially include third-party contractors when asked to disclose entities performing claim processing or auditing. The examiners do not believe this failure was a deliberate attempt to conceal the presence of these third parties, but rather evidence that insurance carriers are sometimes unaware of how much these entities may influence processes affecting members.

Another group of contracted vendors, software companies, provides health care claims auditing tools. These companies often use artificial intelligence (“AI”), including models and algorithms designed to detect improper or incorrect payments, to support claims compliance and both internal and external audits. Whether insurance carriers have evaluated the design and accuracy of this software or conducted periodic testing to ensure it functions correctly was not examined. Future reviews should consider incorporating a review of newer AI-based claims auditing tools. Lastly, verifying that third-party administrators forward consumer and provider complaints directly back to the insurance carrier can be difficult when the third party controls the network. Insurance carriers must address this requirement in contractual agreements and monitor compliance.

The examination verified that all the insurance carriers reviewed had QTL policies and procedures. Many companies provided not only the QTL but also additional information about their comparative analysis process. The examination also showed that the subject insurance carriers made significant improvements in MHPAEA compliance by updating processes and procedures, documenting state-specific requirements, and adopting new technologies, such as CAQH tools.

The Division conducted 21 examinations across 13 insurer groups. Of these, 20 examinations were completed as of December 8, 2025, with the remaining examination completed on May 15, 2026. These examinations included domestic, regional, and national companies subject to MHPAEA. This review was a high-level assessment focusing primarily on processes, procedures, and aggregate data. Future examinations may cover topics such as claims, NQTL comparative analysis, third-party administrator auditing, and AI use.

Breakdown of Treatment Authorization Data

According to M.G.L. c. 176O, carriers may establish utilization review systems that evaluate the medical necessity of a requested service. If a carrier denies or modifies a request, the carrier is required to notify the covered member about this adverse determination within 2 days and provide information about how to appeal any such adverse determination both within the member's carrier's internal appeal system and if still denied through that appeal through an external review by an independent review board coordinated through the Office of Patient Protection.

Each carrier submitted a report of services requested, authorized or denied and of appeals that were conducted that were either overturned or upheld. For 2024, carriers reported that 708,892 medical requests were made for 510,723 inpatient days and 37,348,672 medical services. In addition, carriers reported that 40,795 behavioral health requests were made for 174,055 inpatient days in behavioral health beds and 5,844,779 outpatient behavioral health visits/services.

Among the medical requests, 652,471 (92.0%) were authorized, 6,009 (0.8%) were modified and 49,981 (7.1%) were denied. Of those denied, 5,057 of the denials were appealed within the company; 2,456 (48.6%) of the appealed denials were approved and 2,601 of the appealed denials remained denied. Of those denied on appeal, 52 were sent for an external appeal coordinated through the Office of Patient Protection; 16 (30.8%) of those sent for external were overturned and 36 (69.2%) were upheld.

Among the behavioral health requests, 39,220 (95.7%) were authorized, 186 (0.5%) were modified and 1,373 (3.7%) were denied. Of those denied, 282 of the denials were appealed within the company; 135 (47.9%) of the appealed denials were approved and 147 (52.1%) of the appealed denials remained denied. Of those denied on appeal, 8 were sent for an external appeal coordinated through the Office of Patient Protection; 6 (75.0%) of those sent for external were overturned and 2 (25.0%) were upheld.

Based on the information reported by the carriers, it does not appear that there is a material difference between how requests were processed for medical and behavioral health services.

Consumer Complaint Information

The Consumer Services Unit ("CSU") responds to inquiries and assists consumers in resolving insurance complaints or disputes against insurers, producers and other licensees. The Unit works to ensure that consumers are being treated in a fair and consistent manner by licensees and helps consumers resolve various issues including claims, billing, benefits, underwriting and misrepresentation of policies, premium refunds, and cancellation concerns.

The CSU works closely with the Bureau of Managed Care ("BMC") to review consumer complaints that are pertinent to health carriers' managed care practices. The BMC is responsible according to the provisions of section 3 of M.G.L. c. 176O and 211 CMR 52.18 to investigate any managed care practices that are not compliant with statutory and regulatory standards, including whether health plan benefits may inappropriately differ between covered benefits for behavioral health and non-behavioral health services.

The Division is also charged under section 8K(a)(i) of M.G.L. c. 26 with "evaluating and resolving all consumer complaints alleging a carrier's non-compliance with state or federal laws related to mental health and substance use disorder parity." This includes any "consumer complaints alleging a carrier's non-compliance with a state or federal law related to mental health and substance use disorder parity, including any matters referred to the commissioner by the office of patient protection under subsection (g) of section 14 of chapter 176O."

Process

The Division issued Bulletin 2013-06 and promulgated 211 CMR 154.00 to provide information about submitting complaints regarding alleged non-compliance with state and federal laws for mental health parity. The Bulletin explained how consumers and their representatives could file a complaint or make a call to present information about any alleged complaint. All calls and complaints are made with the Consumer Services Unit so that they may be properly logged for further review. In addition to complaints that may be logged with the Consumer Services Unit, the Division holds monthly meetings with the Office of Patient Protection (OPP) in order to discuss complaints that may have been made with OPP including those made associated with Mental Health Parity concerns.

In order to review all filed Mental Health Parity complaints, the Division created an inter-agency team composed of representatives from the Consumer Services Unit, Bureau of Managed Care, Legal Unit, Health Care Access Bureau and Special Investigations Unit to review all Mental Health Parity complaints filed with the Consumer Services Unit. The inter-agency team meets at least monthly or more frequently when a complaint has been specifically filed as a Mental Health Parity complaint. Since many complaints are filed without being specifically identified as a Mental Health Parity complaint, each complaint made that pertains to behavioral health services are reviewed by the inter-agency team.

Within calendar year 2024, a total of 3,151 complaints were filed with the Division's Consumer Services Unit. A total of 169 (5.4%) of the total were complaints about behavioral health. Of the total filed complaints, only two were specifically associated as mental health parity complaints.

During 2024, the Division's Consumer Service Unit received 197 complaints associated with behavioral health issues out of a total 3,151 overall complaints. Of the 197 complaints, 54 were resolved in favor of the consumer, 76 were resolved in favor of the carrier and 41 were not under the jurisdiction of the DOI. (The 41 complaints not under the jurisdiction of the Division were forwarded to a different agency because the consumer was covered under an out-of-state, government or self-funded plan not subject to the Division's oversight.) Of the total filed 2024 complaints, only 2 were identified as mental health parity complaints.

During 2023, the Division's Consumer Service Unit received 192 complaints associated with behavioral health issues out of a total 3,249 overall complaints. Of the 192 complaints, 72 were resolved in favor of the consumer, 89 were resolved in favor of the carrier and 44 were not under the jurisdiction of the DOI. (The 44 complaints not under the jurisdiction of the Division were forwarded to a different agency because the consumer was covered under an out-of-state, government or self-funded plan not subject to the Division's oversight.) Of the total 2023 filed complaints, only 1 was identified as a mental health parity complaint.

The majority of complaints were associated with reimbursement for provider services or access to out-of-network care.

Educational or Corrective Action Taken

While all the responding carriers indicated that no corrective actions were required based on internal assessments that each carrier was in compliance with federal and state Mental Health Parity laws, the Division is looking to take a number of steps to monitor compliance going forward, as described in the next section of this report.

Next Steps

Annually, the Division performs a review of 21 carriers' evidences of coverage, schedules of benefit and related information for the individual, small group and large group markets to verify that carriers include quantitative treatment limitations that are no more restrictive for mental health/substance use services than for medical/surgical services. Additionally, the Division collects a large number of documents as part of a bi-annual managed care accreditation process for these 21 carriers. The Division intends to expand on this bi-annual review process by delving further into these documents with a particular focus on verifying compliance with MHPAEA and state Mental Health Parity laws.

As part of this process, the Division aims to compare carriers' utilization review policies and procedures; carriers' processes to establish guidelines for Medical Necessity; and perform a review of the Carrier's network adequacy standards. One additional component of the review process going forward will focus on differences among carriers who perform mental health/substance use utilization review in-house compared to carriers who delegate those functions to an external entity.

The Division currently holds regular internal meetings to discuss consumer complaints related to possible Mental Health Parity violations. The Division intends to continue to hold these regular meetings and further plans to have training sessions with staff from the Divisions Consumer Services Unit to help staff identify potential Mental Health Parity trends and concerns.

The Division created a new process for the review of Mental Health Parity compliance as a result of the creation of M.G.L. c. 26, section 8M. Because this first year created new requirements for the carriers, the Division intends to update the instructions filing guidance and the file submission process to further clarify submission requirements and to streamline the review process going forward.

While for this report we reviewed only those materials that were required as part of the new statute, for future reports we may look at previously filed information from the carriers to help identify areas where improvements may be suggested.

Appendix A

List of Responding Carriers

4 Ever Life Insurance Company
Aetna Health, Inc. (a Pennsylvania Corporation)
Aetna Health Insurance Company
Aetna Life Insurance Company
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Blue Cross and Blue Shield of Massachusetts, Inc.
Boston Medical Center Health Plan, Inc. (d/b/a WellSense Health Plan)
Cigna Health and Life Insurance Company
ConnectiCare of Massachusetts, Inc.
Fallon Community Health Plan, Inc.
Harvard Pilgrim Health Care, Inc.
Health New England, Inc.
HPHC Insurance Company, Inc.
Mass General Brigham Health Insurance Company
Mass General Brigham Health Plan, Inc.
Tufts Associated Health Maintenance Organization, Inc.
Tufts Health Public Plans, Inc.
Tufts Insurance Company
United States Fire Insurance Company
UnitedHealthcare Insurance Company
Wellfleet Insurance Company