THE KENNEDY FORUM

ENSURING COVERAGE OF

BEHAVIORAL HEALTH EMERGENCY SERVICES

ABOUT US

SINCE 2013, THE KENNEDY FORUM (TKF) HAS BEEN LEADING A NATIONAL EFFORT TO ACHIEVE SYSTEM REFORM IN THE U.S. HEALTH CARE SYSTEM BY ADVANCING EVIDENCE-BASED PRACTICES, POLICIES, AND PROGRAMMING FOR THE PREVENTION, TREATMENT, AND RECOVERY OF BRAIN ILLNESSES – SPECIFICALLY MENTAL HEALTH AND ADDICTION.

FORMER CONGRESSMAN PATRICK J. KENNEDY LED A COALITION OF DIVERSE STAKEHOLDERS TO PASS THE MOST TRANSFORMATIVE LEGISLATION IN 50 YEARS, THE BIPARTISAN MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT. SINCE LEAVING CONGRESS, HE HAS LEVERAGED THAT UNIQUE ROLE TO COALESCE A GROWING SET OF DIVERSE STAKEHOLDERS TO ADVANCE THE NEXT GENERATION OF MENTAL HEALTH AND ADDICTION POLICY THROUGH TKF.

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The creation of 988 as the three-digit phone number for people experiencing behavioral health emergencies across the United States presents a critical opportunity to standardize and increase access to the entire crisis response continuum of behavioral health care.[1] Effective and comprehensive crisis response continuums should include preventive outreach and engagement of people at risk, crisis call centers, mobile crisis teams, crisis stabilization options, and community-based support after a behavioral health emergency. Today, much of this continuum remains underfunded, understaffed, or altogether nonexistent.

Individuals experiencing behavioral health emergencies are often treated in costly hospital emergency departments, settings which have limited resources available to connect individuals to robust long-term services and supports, or services to address social determinants of health. From the continuing toll of the overdose crisis to the grief and isolation of the COVID-19 pandemic, now is the time for leaders and policymakers to ensure that behavioral health emergency services are treated and covered as comprehensively as medical emergencies. A critical component to securing coverage for these services lies in ensuring commercial coverage for emergency behavioral health services Currently, commercial insurance coverage of behavioral health services, including emergency services, remains meager at best.

1. For the purposes of this brief, "behavioral health emergencies" and "behavioral health crises" are synonymous. We generally prefer "behavioral health emergency" to avoid any connotation that an individual's "crisis" is their fault. Second, relevant health insurance laws primarily use the term "emergency," which is also a classification of care under the Mental Health Parity and Addiction Equity Act of 2008. Nonetheless, in certain instances (e.g., describing the "crisis continuum of care"), we will use the term "crisis" because it is commonly in use.

THE OPPORTUNITY OF 988

Response to individuals experiencing mental health or substance use emergencies varies dramatically across the United States. Calling 911 has long been the default response in many parts of the country, which can lead to inappropriate treatment and even traumatic or deadly encounters with law enforcement.[2] However, the enactment of the National Suicide Hotline Designation Act in September 2020 has presented a new opportunity for reimagining and building a full crisis response system in the United States. The law designates 988 as the new three-digit phone number for people experiencing a behavioral health[3] emergency, expanding the scope of the current National Suicide Prevention Lifeline.[4]

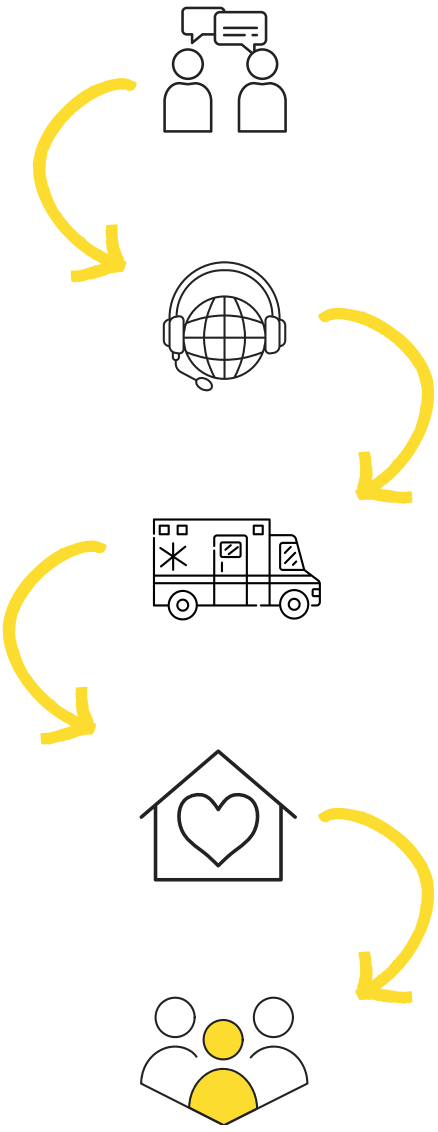
As of July 2022, this three-digit number is now available across the country for calls, texts, and chat for behavioral health emergencies. While an important improvement, having a number to call is only as effective as the response to that call: individuals in crisis need someone to talk to, someone to respond, and somewhere to go.[5] Further, 988 is only one piece of a comprehensive crisis response continuum of care that ideally supports people before, during, and after a behavioral health emergency. As illustrated in Figure 1, a crisis response continuum of care should include preventive outreach and engagement of people at risk (including by peer support teams); crisis call center hubs; mobile crisis teams; crisis stabilization options; and community-based support after a behavioral health emergency.

2. Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System. (2021). https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/988-Crisis-Response-Report-November-FINAL.pdf
3. In this report, "behavioral health" is generally used to refer to both mental health and substance use conditions and associated services, unless otherwise specified.
4. National Alliance on Mental Illness. (2022). 988: Reimagining Crisis Response. https://www.nami.org/Advocacy/Crisis-Intervention/988-Reimagining-Crisis-Response
5. Ibid.

FIGURE 1

CONTINUUM OF CARE

CRISIS RESPONSE



OUTREACH & ENGAGEMENT OF PEOPLE AT RISK

MANY PEOPLE IN THE EARLY STAGES OF CRISIS NEED REFERRAL TO APPROPRIATE SERVICES AND SUPPORTS.

CRISIS CALL CENTER HUBS

EVIDENCE SUGGESTS THAT MOST CRISES CAN BE RESOLVED BY SKILLED TELECOMMUNICATION RESPONDERS.

MOBILE CRISIS TEAMS

MOBILE CRISIS TEAMS ARE ABLE TO RESOLVE THE MAJORITY OF CRISES IN THE COMMUNITY.

CRISIS STABILIZATION OPTIONS

THOSE REQUIRING A HIGHER LEVEL OF CARE SHOULD HAVE MULTIPLE OPTIONS, SUCH AS CRISIS STABILIZATION OR HOSPITALIZATION, CORRESPONDING TO THEIR LEVEL OF NEED.

POST-CRISIS COMMUNITY BASED SUPPORT

WITH APPROPRIATE CARE AND SUPPORT, MOST PEOPLE ARE ABLE TO REMAIN STABLE IN THEIR COMMUNITIES POST-CRISIS.

SOURCE: CONSENSUS APPROACH AND RECOMMENDATIONS FOR THE CREATION OF A COMPREHENSIVE CRISIS RESPONSE SYSTEM, 2021

CURRENT STATUTORY LANDSCAPE OF EMERGENCY SERVICES

To understand what changes are needed, it is first important to understand where current law stands. This section provides an overview of the major federal laws governing emergency services, which have evolved to expand the settings and conditions for which service provision and insurance coverage is required. The role and importance of state laws is later discussed.

EMERGENCY MEDICAL TREATMENT & ACTIVE LABOR ACT

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide a medical screening examination to anyone experiencing a medical emergency condition or requesting such an examination to determine if an emergency medical condition exists, regardless of the person's insurance status, whether the hospital is in the insurer's network, or the patient's ability to pay.[6]

Enacted in 1986, EMTALA was designed to prohibit hospitals from transferring uninsured or Medicaid patients to public hospitals, thus ensuring patients were stable for transfer and shifting responsibility for "charity care" beyond public hospitals to all hospitals.[7] Under EMTALA, hospitals participating in Medicare (nearly all of the nation's hospitals) that operate emergency departments must examine and treat emergency medical conditions of all patients in a fully non-discriminatory manner.[8] A critical contribution of EMTALA is its definition of "emergency medical condition," which is defined as:

> **A CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) SUCH THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN PLACING THE INDIVIDUAL'S HEALTH [OR THE HEALTH OF AN UNBORN CHILD] IN SERIOUS JEOPARDY, SERIOUS IMPAIRMENT TO BODILY FUNCTIONS, OR SERIOUS DYSFUNCTION OF BODILY ORGANS.**[9]

EMTALA requires that a patient who comes to a hospital and has been determined to have an emergency medical condition be examined and treated to stabilize the condition or be transferred by the hospital after stabilization that reasonably assures that "no material deterioration" is likely to occur to the emergency medical condition (or pregnant person and unborn child) during a transfer to another facility.[10] EMTALA provides an important foundation for protecting the immediate health of individuals in emergency situations by requiring hospitals to provide treatment in order to maintain status as a Medicare provider.

However, EMTALA does not account for the various new types of health treatment facilities that now exist; does not explicitly address emergencies related to behavioral health conditions (though, it does not exclude these conditions); and does not give specified directives to insurance companies about emergency coverage and billing, leaving significant ambiguity in these realms.

6. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd. (1986). https://www.law.cornell.edu/uscode/text/42/1395dd#e_3
7. American College of Emergency Physicians. (n.d.). EMTALA Fact Sheet. https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/#:~:text=The%20Emerg
8. Ibid.
9. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd. (1986). https://www.law.cornell.edu/uscode/text/42/1395dd#e_3
10. Ibid.

NO SURPRISES ACT

The federal No Surprises Act (NSA), which went into effect on January 1, 2022, is best known for providing consumers protection against surprise medical bills, but it is also critical to the landscape of emergency services. Founded upon EMTALA, **NSA's emergency provisions also contain three key changes that impact the behavioral health emergency continuum of care: restrictions on balance billing, expansion of the definitions of emergency conditions and services, and expansion of facility settings where emergency services must be reimbursed.**

Filling a critical gap in the Affordable Care Act's (ACA) emergency services provisions, NSA enacted more robust protections against balance billing patients, or the practice of providers to bill patients for the remaining balance of costs that their insurer will not cover. Under NSA, out-of-network providers cannot balance bill patients for emergency services above the equivalent cost-sharing obligation for in-network services under their plan.[11]

Next, the NSA definition of emergency condition largely mirrors the definition established in EMTALA, but the NSA's Interim Final Rules and subsequent documentation from the Department of Labor specifically state that mental health conditions and substance use disorders are included in this definition, removing any question about whether an emergency condition includes them.[12, 13]

11. Hoffmann, S.M. (2021). Federal Agencies Release Interim Final Rule to Implement the No Surprises Act. The National Law Review, 12(192). https://www.natlawreview.com/article/federal-agencies-release-interim-final-rule-to-implement-no-surprises-act#:~:text=In%20short%2C%20the%20Interim%20Final,may%20have%20protection%20from%20balance
12. No Surprises Act; Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36879 (July 13, 2021). https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf
13. U.S. Department of Labor. (2022, Aug 19). FAQS About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf

Further, NSA defines "emergency services" to include a "medical screening examination" that is within the capability of the emergency department or independent freestanding emergency department (discussed more below) and its staff to stabilize the patient, including ancillary services routinely available to evaluate emergency medical conditions.[14]

Under its definition of emergency services, NSA also protects additional services, such as pre-stabilization services provided after the patient is admitted to the hospital from the emergency department, services rendered after stabilization as part of outpatient observation, or those rendered as part of an inpatient or outpatient stay in relation to the visit in which emergency services were necessary.[15] These go beyond EMTALA's requirements for a medical screening examination and treatment necessary to stabilize a patient, thereby expanding the types of services that are protected from balance billing and other NSA requirements.

Unlike EMTALA, NSA has provisions for insurers, specifying that coverage for emergency services cannot be denied based on the final diagnosis.[16] The Interim Final Rule requires insurers to cover emergency services based on whether a "prudent layperson" – a standard that exists in EMTALA and places obligations on emergency departments – would reasonably seek such services. This standard disallows the previous practice of denying coverage based on ultimate diagnosis and waiting for the beneficiary to appeal the denial before conducting a thorough claim review.[17] **Thus, emergency services are covered by law if they pass this prudent layperson standard (i.e., whether a prudent layperson would believe that an emergency exists), regardless of any clinical determinations made.**[18]

Finally, as described in the earlier definition of emergency medical services, NSA also expands the definition of facility settings beyond a strictly hospital-based emergency department by newly defining an independent freestanding emergency department as: "a healthcare facility that— (i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) provides any of the emergency services."[19]

Even if a facility is not licensed under this exact title, this definition is intended to include any health care facility that is geographically separate from a hospital and licensed by its state to provide emergency services.[20] This may include "urgent care" facilities if a state licenses such facilities to provide services that meet the NSA definition of "emergency services."[21]

This provision is critical for a key part of the behavioral health crisis services continuum of care – crisis receiving and stabilization services, which provide pre-stabilization services in facilities that are separate and distinct from hospital-based emergency departments. (The NSA, as discussed in detail below, does not cover mobile crisis services that occur outside a facility.) Thus, these three elements of the NSA create an unambiguous requirement that insurers cover, without regard to network status, all emergency services, including behavioral health emergencies, that are provided in state-licensed facilities.

In other words, **health plans must reimburse, without prior authorization or regard to provider network status, any services that meet the NSA definition of "emergency services," and providers cannot balance bill patients for out-of-network services above their plan's cost-sharing arrangement for in-network services.** The consumer protections of NSA also specify that behavioral health diagnoses made during an emergency visit, whether or not medical treatment was necessary during the same visit, cannot be used to deny insurance coverage.

14. Consolidated Appropriations Act, 2021. H.R. 133, 116th Congress. (2021). https://www.naag.org/wp-content/uploads/2021/02/No-Surprises-Act.pdf
15. Hoffmann, S.M. (2021). Federal Agencies Release Interim Final Rule to Implement the No Surprises Act. The National Law Review, 12(192). https://www.natlawreview.com/print/article/federal-agencies-release-interim-final-rule-to-implement-no-surprises-act
16. Ibid.
17. Ibid.
18. Ibid.
19. Consolidated Appropriations Act, 2021. H.R. 133, 116th Congress. (2021). https://www.naag.org/wp-content/uploads/2021/02/No-Surprises-Act.pdf
20 U.S. Department of Labor. (2022, Aug 19). FAQS About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55. https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf
21. Hoffmann, S.M. (2021). Federal Agencies Release Interim Final Rule to Implement the No Surprises Act. The National Law Review, 12(192). https://www.natlawreview.com/print/article/federal-agencies-release-interim-final-rule-to-implement-no-surprises-act

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act (MHPAEA) is also critical to understanding the landscape of coverage for behavioral health emergency services. As the federal parity law, MHPAEA prohibits most types of commercial health plans and all comprehensive Medicaid managed care plans from imposing non-quantitative treatment limitation (i.e. any limitation on the scope or duration of care that is not numerically expressed) on mental health or substance use disorder benefits that is not comparable to, or more stringently applied than, the same limitation imposed upon medical and surgical benefits.

For example, a plan could not impose a prior authorization requirement for MH/SUD outpatient services while not requiring prior authorization for any (or a limited portion of) medical and surgical benefits. While MHPAEA does not require mental health coverage, nearly all commercial health plans subject to MHPAEA cover some mental health or substance use disorder services, either due to employers' practice or the Affordable Care Act's essential health benefit requirements (applicable to small group and individual plans). Once any behavioral health services are covered, all coverage must meet MHPAEA's requirements. Medicaid managed care plans also routinely cover behavioral health services.

MHPAEA's rules apply within each of six classifications of care,[22] one of which is "emergency." A health plan's compliance with MHPAEA is separately determined within each of these six classifications. Thus, for plans subject to MHPAEA that cover any behavioral health services, any non-quantitative treatment limitation placed on behavioral health emergency services must be consistent with MHPAEA.

This is particularly important because, while the NSA's rules on behavioral health emergency services that occur within independent freestanding emergency departments unambiguously require health plans to cover these services, these rules do not cover emergency services provided outside either an emergency department or an independent freestanding emergency department. Unfortunately, therefore, the NSA does not require insurance coverage of behavioral health crisis continuum services that occur outside facilities, including mobile crisis response.

Nonetheless, MHPAEA does apply to all non-quantitative treatment limitations, including within the emergency classification of care, into which mobile crisis services almost certainly must be placed.[23] As a result, any limitation on the scope or duration of coverage of mobile crisis response services – including an exclusion of such services – must meet MHPAEA's comparability and stringency tests with respect to the same limitation applied to physical health emergency services. The statutory text of MHPAEA makes clear that a treatment limitation cannot be applied to behavioral health services that fall within a particular classification if that same treatment limitation is not also applied to physical health benefits within that classification.[24] Therefore, MHPAEA offers a strong basis for requiring commercial coverage of mobile crisis response services.

22. The six classifications of care are emergency, in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, and prescription. For managed care plans, there are only four classifications (out-of-network inpatient and outpatient classifications are excluded).
23. While health plans have flexibility in the classification of care to which they assign benefits for purposes of MHPAEA compliance, their method of classification must be consistent across medical/surgical and behavioral health benefits. Every health plan of which we are aware assigns emergency transport and emergency department benefits to the "emergency" classification. Under the No Surprises Act, insurers must cover crisis receiving and stabilization services that are provided in state-licensed facilities ("independent freestanding emergency departments") and meet the federal definition of "emergency services." It would, therefore, be illogical for these services to be assigned to any classification category other than "emergency." Furthermore, mobile crisis response services are provided earlier in an individual's behavioral health emergency. Therefore, any placement of mobile crisis services in a classification other than "emergency" for MHPAEA purposes would almost certainly not survive basic scrutiny.
24. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. § 300gg-26(a)(3)(A)(ii). (2008). https://www.law.cornell.edu/uscode/text/42/300gg-26

COMMERCIAL INSURANCE COVERAGE

MOBILE CRISIS RESPONSE SERVICES

Broadly speaking, commercial insurers do not currently cover mobile crisis response services when enrollees need these benefits. Instead, publicly funded agencies are left paying for and administering these services. Mobile crisis teams are currently funded by federal, state, and local discretionary funds and, increasingly, by Medicaid (for Medicaid beneficiaries). States are also beginning to take advantage of the opportunity to assess telecommunication user fees to pay for mobile crisis response services. The option for states to adopt such fees was authorized by the National Suicide Hotline Designation Act.[25]

Because taxpayer dollars are (inadequately) funding mobile crisis services for Americans enrolled in commercial insurers, the limited funding does not go far enough to meet current needs. This lack of commercial insurance financing, therefore, significantly impairs the ability to build a robust behavioral health emergency response system. To help build this critical part of the crisis continuum so that it can be there when individuals need it, policymakers must take steps to ensure that commercial insurers reimburse mobile crisis response services.

COVERAGE OF MOBILE CRISIS RESPONSE SERVICES SHOULD BE CHARACTERIZED BY ALL THE FOLLOWING:

- ✓ INSURANCE PAYMENT IS REQUIRED FOR ANY SITUATION IN WHICH A PRUDENT LAYPERSON WOULD HAVE BELIEVED AN EMERGENCY EXISTED;
- ✓ PRIOR AUTHORIZATION IS PROHIBITED;
- ✓ PROVIDER NETWORK STATUS DOES NOT MATTER / ALL COST-SHARING IS AT IN-NETWORK LEVELS; AND
- ✓ BALANCE BILLING BY PROVIDERS IS PROHIBITED.

All of these are critical existing federal requirements for other emergency services. They exist because, during an emergency, an individual cannot be expected to obtain prior authorization or locate an in-network provider without jeopardizing their health or safety. Individuals also need to be protected from anything other than their in-network cost sharing amount.

25. National Suicide Prevention Hotline Designation Act of 2020, S. 2661, 116TH Congress. (2020). https://www.congress.gov/bill/116th-congress/senate-bill/2661

ALIGNMENT THAT PROMOTES PARITY

WASHINGTON STATE CASE STUDY

The State of Washington has taken strong action to align state law with NSA and provide these critical protections to commercially insured individuals, offering a unique case study in coverage of behavioral health emergency services.

In March 2022, Washington enacted legislation HB 1688, based on the NSA and further to ensure parity in emergency services coverage by creating an expansive definition of "behavioral health emergency services provider," which includes all state licensed providers of behavioral health emergency services regardless of whether the services occur in- or outside of a facility.[26]

By creating a requirement for insurers to cover all behavioral health emergency services that are provided by a behavioral health emergency services provider in this manner, Washington has taken a giant leap forward by requiring insurers to cover most of the continuum of behavioral health emergency services.[27]

Washington's Office of the Insurance Commissioner has made clear that the definition of "behavioral health emergency services provider" now written into state law ensures that plans are meeting their MHPAEA obligations.

In a May 2022 memorandum, the Insurance Commissioner points out that behavioral health emergency services providers are "equivalent to the full range of emergency and crisis services for medical and surgical conditions."[28]

The memo highlights that insurers' restrictions or exclusions based on "facility type" that subsequently limit the scope of coverage for services is a non quantitative treatment limitation under MHPAEA's rules.[29]

The memo further demonstrates that an exclusion of providers of behavioral health emergency services (e.g. mobile crisis response providers) would not comply with MHPAEA because no such exclusion is applied to physical health emergency services and that therefore HB1688's requirements ensure compliance with federal parity requirements by ensuring that treatment for behavioral health emergency services is not subject to discriminatory limitations.[30]

The enactment of Washington HB1688 marked an important step to align state laws with NSA and ensure compliance with MHPAEA, highlighting an avenue that can be pursued by other states.

26. W.A. 67th Leg. Engrossed Second Substitute House Bill 1688. Reg. Sess. 2021-2022. (2022). https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/House%20Passed%20Legislature/1688-S2.PL.pdf?q=20220701121925
27. The new designation includes evaluation and treatment facilities, crisis triage facilities, medical withdrawal management services facilities, and mobile rapid response crisis team services. It does not, however, include outreach and engagement services for people at risk of a behavioral health emergency.
28. Beyer, Jane. (May 6, 2022). Memorandum: Behavioral Health Emergency Services Under E2SHB 1688 (Chap. 263, Laws of 2022). Washington Office of the Insurance Commissioner. https://www.insurance.wa.gov/sites/default/files/documents/e2shb-1688-mhpaea-memo.pdf
29. Ibid.
30. Ibid.

ENSURING COVERAGE OF

BEHAVIORAL HEALTH CRISIS SERVICES

ACTIONS FOR FEDERAL POLICYMAKERS

One way to ensure coverage of behavioral health emergency services is through the enactment of federal legislation. An effort already underway to ensure appropriate coverage of behavioral health emergency services is the Behavioral Health Crisis Services Expansion Act (S.1902 / H.R. 5611) that was introduced in the U.S. Senate in May 2021.

In addition to directing the Secretary of the Department of Health and Human Services (the Secretary) to define minimum requirements for core crisis services, the bill would require crucial coverage of crisis response services in Medicare, Medicaid, TRICARE, Federal Employee Health Benefits plans, group health plans, and individual health plans.[31] Other provisions of the bills include service and quality standards, such as having the Secretary define adequate volume standards, timely care delivery, and capacity to meet the needs of various populations. Simply put, the passage of these congressional bills would establish national standards and expand coverage of crisis response services to additional health plans uniformly across the country. Federal policymakers should additionally ensure that mobile crisis response coverage would be consistent with other emergency services under federal law (i.e., using the prudent layperson standard, prohibiting prior authorization, requiring in-network cost-sharing, and preventing balance billing).

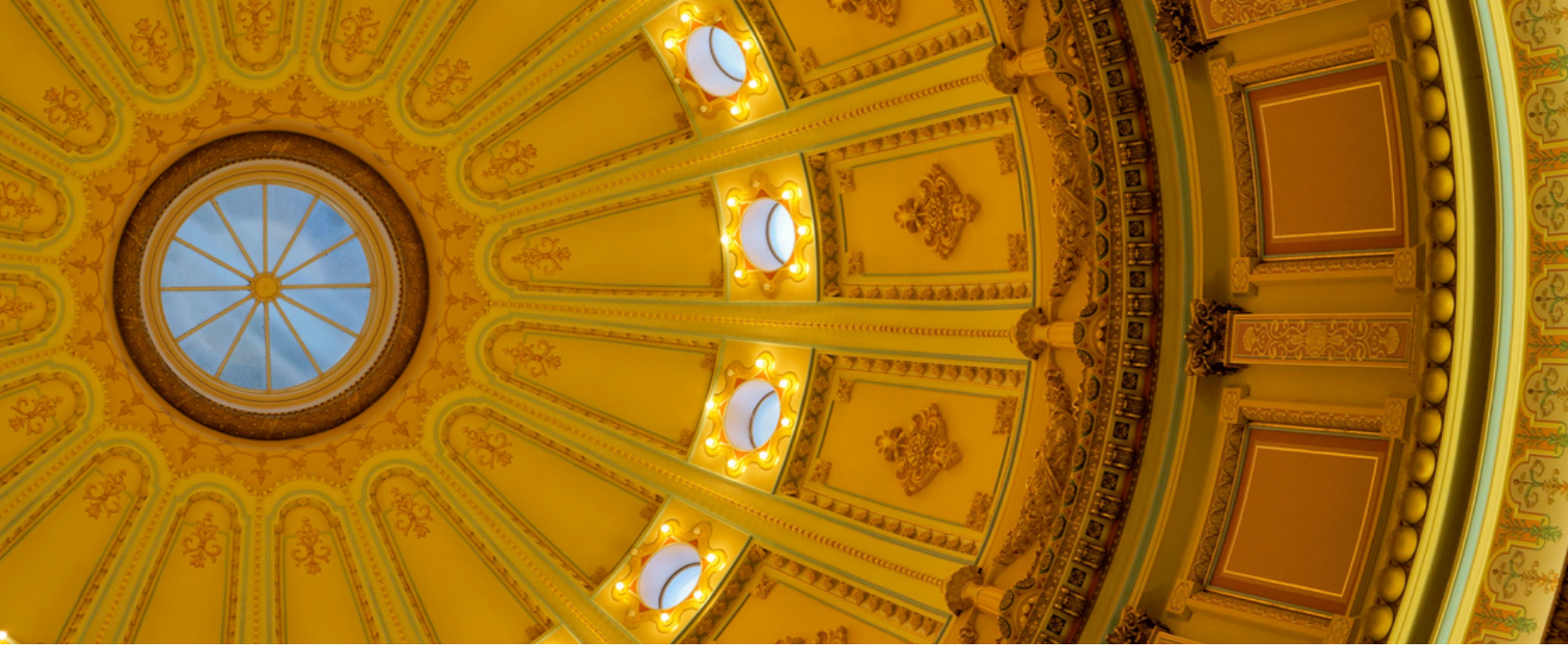
ACTIONS FOR STATE POLICYMAKERS

States should also act to ensure full coverage of the behavioral health crisis continuum, from outreach/engagement services for those at risk of emergencies to post-stabilization services.[32]

To build out a robust behavioral health crisis continuum of care centered around 988, **states need to take action to require commercial insurers to cover behavioral health emergency services – particularly ensuring coverage of mobile crisis response – for their plan members in the same manner insurers would cover physical health emergency services, providing the important protections described above.**

In the absence of commercial insurance reimbursement, the cost of providing behavioral health emergency services will be shifted to taxpayers. If adequate behavioral health services are not provided, taxpayers will pay even higher costs associated with increased disability, unemployment, and criminal legal system involvement associated with improper responses to behavioral health emergencies.

31. Behavioral Health Crisis Services Expansion Act, S. 1902, 117TH Congress. (2021). https://www.congress.gov/bill/117th-congress/senate-bill/1902/text
32. Policymakers may wish to exempt call center costs from a coverage mandate. Because callers' identities are often not known, requiring commercial
insurance coverage is likely to be much more difficult.



STATES SHOULD ENSURE THAT STATE LICENSURE IS AVAILABLE FOR FACILITIES TO PROVIDE BEHAVIORAL HEALTH EMERGENCY SERVICES

To take advantage of NSA coverage requirements for facility-based emergency services, **states should ensure that state licensure is available for facilities to provide behavioral health emergency services.** Such licensure triggers the expansive NSA requirements that insurers cover behavioral health emergency services provided in these facilities ("independent freestanding emergency departments" under the NSA) without prior authorization, provider network status, or the possibility of patient costs beyond in-network cost-sharing.

More broadly, **states should provide licensing to each part of the behavioral health crisis continuum of care and should require health coverage for behavioral health emergency services that are provided along the entire continuum.** This is exactly what Washington did by including, under the definition of "emergency services," examination and treatment provided by a "behavioral health emergency services provider," which the new Washington law defines as the range of listed providers that cover the crisis continuum of care. This expansion of state-licensed settings for the delivery and coverage of behavioral health emergency services will help avoid unnecessary and costly hospital-based emergency department visits, protect individuals from potentially catastrophic out-of-pocket costs, and provide crucial financing to scale up the crisis continuum to respond to all behavioral health crises. Like Washington, **states should make clear that these requirements are necessary for health plans to meet their obligations under MHPAEA to cover behavioral health emergency services at parity with physical health emergency services.** Indeed, even without legislation, states should ensure that health plans are fully in compliance with MHPAEA requirements with respect to behavioral health emergency services.

By taking these actions, states can take critical steps toward building a comprehensive behavioral health crisis continuum of care that prevent unnecessary encounters with law enforcement or visits to hospital-based emergency departments that are usually ill-suited to treat behavioral health emergencies effectively. The momentum garnered by 988 to make improvements to multiple segments of the behavioral health crisis continuum of care is an opportunity that the United States cannot afford to squander. The current statutory landscape of emergency services is broadening to cover more conditions and settings. Both Congress and states should take deliberate action to ensure timely, sustainable, and comprehensive behavioral health emergency care and coverage.

APPENDIX

APPENDIX I

CRISIS CONTINUUM COMMERCIAL COVERAGE OPTIONS BY SERVICE TYPE

To ensure coverage for behavioral health emergencies across the entire crisis continuum, states should require commercial insurers to cover behavioral health emergency services in the same manner insurers would cover physical health emergency services by enacting model legislation and increasing state investigations and enforcement of commercial insurers compliance with the above laws and regulations in state health plans.

988 CONTINUUM	RELEVANT LAW(S)	REQUIREMENTS	STATES' ACTION TO ENSURE COVERAGE
MOBILE CRISIS RESPONSE	The Mental Health Parity and Addiction Equity Act (MHPAEA) applies to any treatment limitation, including limitations on mobile crisis response services.	Given how physical health emergency benefits are classified, the only logical classification of care for mobile crisis response services is also within the "emergency" classification. Given this placement, any treatment limitation imposed on mobile crisis response services must meet federal parity rules when compared to physical health emergency benefits. Treatment limitations (e.g., prior authorization) that are not allowed for physical health emergency services could not be placed on behavioral health emergency services.	Follow Washington State's lead by explicitly requiring health plans to cover mobile crisis response and other behavioral health emergency services by: 1) Taking MHPAEA enforcement action against any treatment limitation, including exclusion of benefits, applied to behavioral health emergency services that is not applied to physical health emergency services; AND/OR 2) Adopting explicit requirements that behavioral health emergency services be covered in the same manner as physical health emergency services. Review any treatment limitations imposed on mobile crisis response services to ensure MHPAEA compliance.
CRISIS RECEIVING & STABILIZATION	The NSA clarifies that insurers are required to treat facility-based crisis receiving and stabilization services without prior authorization or with respect to providers' network status. MHPAEA applies to any treatment limitation.	NSA coverage requirements apply to crisis receiving and stabilization services that meet the definition of "emergency services." NSA prohibits out-of-network providers to balance bill patients for emergency services above the equivalent cost-sharing obligation for in-network services under their plan. MHPAEA applies, but NSA's requirements are stronger.	Ensure that state licensure is available for facilities to provide behavioral health "emergency services," which triggers the expansive NSA requirements that insurers cover behavioral health emergency services provided in these facilities without prior authorization, provider network status, or the possibility of patient costs beyond in-network cost-sharing. Review any treatment limitations imposed on mobile crisis response services to ensure MHPAEA compliance.
PRE & POST STABILIZATION	Same NSA and MHPAEA requirements as listed for crisis receiving and stabilization services.	The NSA protects pre-stabilization services provided after the patient is admitted to the hospital from the emergency department, services rendered after stabilization as part of outpatient observation, or those rendered as part of an inpatient or outpatient stay in relation to the visit in which emergency services were necessary.	Same recommendations as listed for crisis receiving and stabilization services.
OUTREACH, ENGAGEMENT, PREVENTION & EARLY INTERVENTION	While the ACA requires coverage of preventative services given a grade of "A" or "B" by the U.S. Presentative Services Task Force without cost-sharing, coverage for preventative services (including outreach and engagement) is broadly lacking among commercial payers. MHPAEA applies to any treatment limitation.	Some preventive screenings such as depression screenings for those aged 12 and up and screening and behavioral health counseling for alcohol use in adults are recommended by the USPSTF.	Require coverage of prevention and early intervention services, including those provided by peers. Review any treatment limitations imposed on mobile crisis response services to ensure MHPAEA compliance.
CRISIS CALL CENTERS & HUBS	There are no federal laws explicitly requiring commercial coverage of call centers.	Given the privacy of callers' identities and information when they call into crisis call centers, it is likely very difficult to ensure commercial reimbursement for crisis call center operations.	Sustainably fund crisis call centers and hubs through alternative appropriations and supports.

APPENDIX II

MODEL STATE LEGISLATION FOR COVERAGE OF BEHAVIORAL HEALTH EMERGENCY SERVICES

SECTION 1

DEFINITIONS

THE FOLLOWING DEFINITIONS APPLY FOR PURPOSES OF THIS ACT:

1. "Behavioral health emergency services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those experiencing a mental health or substance use disorder emergency. These include, but are not limited to, crisis intervention, mobile crisis teams, and crisis receiving and stabilization services.

2. "Mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

3. "Mobile crisis teams" means a multidisciplinary behavioral health team as defined in the American Rescue Plan Act of 2021 (Section 1947(b)(2) of Public Law 117-2).

4. "Crisis receiving and stabilization services" means facility-provided short-term services (under 24 hours) with capacity for diagnosis, initial management, observation, crisis stabilization and follow up referral services to all persons in a home-like environment.

SECTION 2

COVERAGE FOR BEHAVIORAL HEALTH EMERGENCY SERVICES

1. Every [insurance] policy issued, amended, or renewed on or after [insert date], that provides hospital, medical, or surgical coverage shall cover behavioral health emergency services provided to [an insured] experiencing, or believed to be experiencing, a behavioral health emergency. Coverage of such services shall be without the need for any prior authorization determination and whether the health care provider furnishing such services is a participating provider.

2. [An insured] shall only be responsible for in-network cost sharing. If behavioral health emergency services are provided by a non-participating provider, [the insurer] shall ensure that [the insured] pays no more in cost sharing than [the insured] would pay if the same services were provided by a contracted provider.

3. The [Commissioner] shall enforce federal emergency services coverage requirements, including for behavioral health services provided in independent freestanding emergency departments, pursuant to the No Surprises Act (including 26 U.S. Code § 9816, 29 U.S. Code § 1185e, and 42 U.S. Code § 300gg-111) and its implementing regulations.

4. The [Commissioner] shall verify that each treatment limitation placed on behavioral health emergency services is fully compliant with the federal Mental Health Parity and Addiction Equity Act and its implementing regulations. For each non-quantitative treatment limitation placed on mental health or substance use disorder services within the emergency classification of care, the [Commissioner] shall request each [insurer's] parity compliance analysis prepared pursuant to 42 U.S. Code § 300gg–26(a)(8) and verify that each analysis demonstrates compliance. Behavioral health emergency services shall be placed within the emergency classification of care in the same manner as physical health emergency services.

5. The [Commissioner] shall adopt rules, under [insert relevant section of state law], as may be necessary to effectuate any provisions of this Section.

6. If the [Commissioner] determines that an insurer has violated this section, the [Commissioner] may, after appropriate notice and opportunity for hearing in accordance with [relevant section of code], by order, assess a civil penalty not to exceed [twenty-five thousand ($25,000)] for each violation, or, if a violation was willful, a civil penalty not to exceed [fifty thousand dollars ($50,000)] for each violation. The civil penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this code.

7. An [insurer] shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

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