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Corrective Enforcement Actions

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Corrective Enforcement Actions

State regulators have powerful tools at their disposal to enforce mental health and substance use disorder (MH/SUD) parity laws. Marketplace and fully-insured commercial health plans and most Medicaid plans are subject to these laws, and state regulators are responsible for their oversight and enforcement to ensure that consumers are not subject to discrimination when they need care for these conditions. When health plans are found noncompliant, regulators can employ various tools to ensure plans achieve compliance, maintain it over time, and make consumers whole for violations that have affected them. Corrective enforcement actions must be robust enough to not only bring plans into compliance, but to keep them there—and to ensure that consumers are made whole for any violations. Generally, this requires that multiple types of enforcement tools be employed together.

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State Regulating Authority

While health plans are required to comply with MH/SUD parity laws, state insurance departments are responsible for enforcing parity laws in state-regulated commercial insurance,[1] and the state Medicaid agency and the Centers for Medicare & Medicaid Services (CMS) are jointly responsible for enforcing parity laws in Medicaid. Commercial insurance plans are required by federal statute to perform and document analyses showing that they comply with the law.[2] Many states require the plans they regulate to submit these or similar analyses on a regular basis. Other states use their annual rate and form filing process, targeted market conduct exams, or consumer or provider complaints to identify potential parity violations.[3] States are also required to ensure compliance with parity in Medicaid for individuals in managed care plans, alternative benefit plans, and the Children's Health Insurance Program (CHIP).[4] With respect to Medicaid managed care, states were required to provide documentation of compliance and post it on their websites by October 2017, and update such documentation prior to any change in benefits.[5]

All states give their insurance commissioner authority to suspend or revoke licenses/certificates and to issue fines on health plans for noncompliance with MH/SUD parity violations or any other laws. Commissioners generally also have additional enforcement authority to obtain insurer compliance.[6]

The Problem: Widespread Violations and Ineffective Deterrents

While years of enforcement efforts have led to some concrete improvements and some real examples of compliance, state regulators – including the departments of insurance and the offices of the attorney general[7] – continue to find widespread parity violations among many plans.

Persistent Noncompliance

The U.S. Departments of Labor, Health and Human Services, and Treasury's Federal Mental Health Parity and Addiction Equity Act (MHPAEA) reports to Congress in 2022,[8] 2023,[9] and 2024[10] consistently found:

- Few commercial insurance plans in full compliance with parity requirements
- Compliance analyses either not completed or deeply flawed

Additionally, the U.S. Department of Health & Human Services Office of Inspector General found that all the states it reviewed failed to comply with MHPAEA requirements in their Medicaid managed care organizations, and that CMS failed to ensure such compliance.[11]

Increasing Fines with Limited Impact

More states are imposing fines on commercial insurance companies as they strengthen enforcement (see chart). However, these penalties alone have limited impact. Only 10 of 50 states have issued fines, with total MHPAEA fines since 2020 amounting to approximately $78.7 million. By comparison, the two largest insurers alone reported combined profits of $100 billion from 2020-2023, making these fines trivial relative to industry profits.

As a result of the low stakes nature of corrective actions to date, non-compliance with parity remains high and many consumers do not have access to the MH/SUD care to which the law entitles them.

States with Increasing Fines

California

$50,000,000 against Kaiser Permanente (2023)

Connecticut

$1,075,000 against Oxford and United (2020 and 2021)

Delaware

$1.33 million against United, Optimum Choice, Aetna, Cigna, and Highmark (2021)

Georgia

$20 million against 22 health insurers (2025)

Illinois

$2 million against Cigna, United, BCBS IL, Celtic (2020) and $500,000 against Quartz (2023)

Massachusetts

$900,000 against Harvard Pilgrim, United, Fallon Community Health Plan / Beacon Health Strategies, AllWays Health Partners, BCBS MA, Tufts Health Plan (2020)

Minnesota

$450,000 against Medica Insurance Company and HealthPartners (2023), $450,000 against UnitedHealthcare (2024)

New York State

$2.6 million against Aetna, Oscar Health, and Wellfleet (2021), USDOL Settlement of $18 million against United (2021)

Pennsylvania

$250,000 against UPMC Health Plans (2021), $85,000 against Capital Blue Cross (2023), $205,000 against Highmark (2023)

Virginia

$330,000 settlement with Cigna (2022)

Washington

$500,000 against United (2023)

The Solution:
More Robust Corrective Enforcement Actions

To effectively drive compliance, state regulators should implement a range of more comprehensive and impactful enforcement strategies, which include: ensuring consumers are made whole, corrective action plans, penalties and fines, disallowance of products, contracting requirements, and Medicaid claw backs and withholding.

1. Ensuring Consumers are Made Whole

The first focus should always be on making sure that consumers – both in commercial insurance plans and Medicaid – get the care to which they are entitled by law. Unfortunately, current enforcement rarely includes strong consumer remedies. Much can be done to improve consumer rights, including:

- Mandatory reprocessing of improperly denied claims
- Notice to all consumers and their designated parties to submit claims that should have been covered
- Including private rights of action in state law
- Temporarily barring plans from offering services until they meet compliance

Example: If a health plan is found to have insufficient networks for MH/SUD care, regulators can require the health plan to reimburse members for out-of-network providers until the regulator certifies that the health plan has completed its CAP.

Massachusetts state law authorizes its Division of Insurance to require carriers to reprocess and pay any inappropriately denied MH/SUD claims, notify affected members (or their designees) of their right to file or appeal those claims, and reimburse enrollees for out-of-pocket payments incurred. The **Pennsylvania Department of Insurance** also routinely issues corrective action orders that include reprocessing and repayment of improperly denied claims.[12]

A comprehensive approach that includes mandatory claim reprocessing, clear private rights of action, and restrictions on plan activities in areas where they are found non-compliant until corrective actions are completed and verified.

2. Corrective Action Plans/ Workplans

Corrective Action Plans (CAPs) are written documents that outline the steps health plans must take to address non-compliance issues and achieve full compliance. Strong CAPs should include:

- Clear timelines and measurable benchmarks;
- Defined corrective steps with associated data reporting;
- Independent auditing to monitor progress;
- Established regular auditing processes for monitoring ongoing compliance;
- Incorporate targeted market conduct examinations and specific reporting on Non-Quantitative Treatment Limitations (NQTLs).

Federal agencies like the Department of Labor (DOL) and Centers for Medicare & Medicaid Services (CMS) have established CAP processes that include technical assistance and state reporting requirements.

In 2021, the **Pennsylvania Insurance Department** required UPMC Health Plan to adopt a CAP after a market conduct exam revealed MHPAEA violations.[13] The CAP mandated specific timelines, measurable benchmarks, quarterly data reporting, independent

third-party audits, and targeted NQTL reviews. The Department also embedded quarterly oversight for two years, with authority for follow-up market conduct exams.

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CAPs should feature clear timelines, specific benchmarks with measurable outcomes, regular auditing, and meaningful involvement of consumers and stakeholders in the development and monitoring process.

3. Penalties and Fines

Penalties and fines are an important tool regulators have at their disposal. Financial consequences must be sizable enough to serve as a true deterrent and structured to address consumer harm. Enforcement penalties can also direct funds into system improvements or education initiatives. Regulators should:

- Assess penalties that are proportional to the severity and scope of violations
- Structure penalties to include both monetary fines and mandated investments
- Ensure consumer restitution is a component of financial settlements

Examples of penalties in the form of systems investments include:

- Kaiser in **California**: $150 million in behavioral health delivery system improvements
- United in **Connecticut**: $500,000 for education programs
- UPMC in **Pennsylvania**: $800,000 for consumer education campaigns
- BCBS in **Rhode Island**: $5 million for mental health prevention and early intervention programs

Connecticut's Public Act No. 25-94 (SB 10) codified into Title 38a[14] authorizes the Insurance Commissioner to impose civil penalties on insurers who fail to comply with MHPAEA reporting and parity requirements, establishes a structured penalty schedule of up to $100 per product line per day, capped annually at $625,000 per insurer, and permits the use of outside experts to assist in investigations and strengthens transparency by ensuring parity compliance reports are publicly accessible.

Pennsylvania's Health Insurance Coverage Parity and Nondiscrimination Act (Article VI-B) allows the Insurance Commissioner to impose civil penalties of up to $10,000 per willful violation with a maximum of $500,000 per calendar year.[15]

And, **Massachusetts** allows its Insurance Commissioner to impose penalties of $100 per day, with a maximum annual penalty of $1,000,000.

Penalties and fines that are:

- Substantial enough to impact health plan behavior
- Assessed regularly for all identified issues
- Calculated on a per member/enrollee affected basis to ensure proportionality
- Structured to guarantee direct consumer benefit from enforcement actions

4. Disallowance of Products

State regulators have authority to suspend or revoke licenses or prevent non-compliant health care products from being marketed or sold in their state. The political nature of regulation means disallowance is rarely used, with most disputes between regulators and plans ending in settlement agreements rather than product disallowance. However, state regulators can use their authority to:

- Establish clear criteria for when disallowance will be considered
- Create a graduated enforcement approach that includes disallowance for repeated or severe violations
- Develop transparent processes for health plans to address violations and regain compliance status

Rhode Island allows for the suspension or revoking of licenses where plan violations are found, supplementing monetary penalties for found violations.[16]

A transparent framework that clearly defines circumstances under which products will be disallowed, with implementation that prioritizes consumer protection over political considerations.

5. Contracting Requirements

CMS rules[17] require states to include parity compliance and documentation clauses in Medicaid contracts, including public posting of analyses and corrective requirements. Yet OIG reviews have found widespread failures among states to include such language,[18] underscoring the need for explicit contract mandates. Notwithstanding contract requirements in many states, it is far less common for states to conduct ongoing analyses of compliance with MHPAEA in Medicaid.

State Medicaid programs can use compliance as a qualifying factor in state contracting decisions for Medicaid managed care organizations (MCOs). Plans that fail parity compliance reviews should be disqualified from Requests for Proposals (RFPs).

State agencies can:

- Include parity compliance assessments in MCO selection criteria;
- Make eligibility for Request for Proposal (RFP) processes contingent on demonstrated parity compliance;
- Establish ongoing compliance monitoring throughout contract periods;
- Provisions for contract termination if significant violations emerge during the contract period.

Several state contracts offer good models:[19]

- **Arizona** requires a parity analysis and submission in advance of implementing any contract modification, amendment, novation, or other change that may affect compliance; requires documentation of NQTL analysis; and requires prompt filing of corrective action plans.
- **Colorado** requires an external quality review organization to perform an annual review of MCO policies and procedures, including utilization management practices, to ensure MHPAEA compliance.
- **Missouri** sets out the full list of NQTLs that must be examined, consistent with federal regulations, and includes a liquidated damages assessment for failure to submit a parity compliance report or other deliverable.
- **New Hampshire** requires semi-annual reporting of parity compliance with specific attention to beneficiary access to non-participating providers for MH or SUD benefits and rate comparisons to ensure access to MH services; and a liquidated damages assessment for continued failure to comply with the MHPAEA.
- **Ohio** requires Medicaid MCOs to submit to ongoing monitoring and annual reporting using its MHPAEA Compliance Assessment Tool and requires submission using this tool prior to implementation of a new clinical coverage policy, financial requirement, or change in benefits or limitations.
- **Rhode Island** requires MCOs to publish their MHPAEA policy and procedure on their websites and, for suspected parity violations, to direct members through their grievance and appeal procedures, and track parity complaints using the State's approved template.

Require plans to demonstrate full parity compliance through comprehensive analyses to be considered for Medicaid RFPs, with provisions for contract termination if significant violations emerge during the contract period.

6. Medicaid Claw Backs and Withholding

State Medicaid programs can include in their contracts with MCOs that they will claw back funds already spent or withhold new funds when MCOs are out of parity compliance. States can control the way that their contractors spend public funds, and states should not support contractors that violate federal and state law in ways that impact beneficiaries' access to MH/SUD care.

State agencies can:

- Include clear claw back and withholding language related to parity compliance in MCO contracts
- Monitor MCO compliance with parity and consistently and fairly apply claw back and withholding provisions in instances of non-compliance

7. Other Considerations

States can go further by codifying compliance thresholds in external review systems. This is when states make different levels of fines and other corrective actions applicable at different levels of non-compliance, either based on the gravity of the non-compliance or the number of similar instances of non-compliance.

Example: *California's* *Senate Bill 363, The Health Insurance Accountability Act (in legislative process in 2025)* would require evaluation of overturned external reviews. If over 50% of behavioral health cases are overturned, fines are levied and escalate for each additional reversal. The first violation begins at $50,000, second violations range from $100,000–$400,000, and any subsequent violations come in at $1 million minimum. Failure to report triggers additional fines.

Transparent, data-driven enforcement mechanisms that establish clear compliance thresholds with meaningful consequences for violations, combined with public reporting requirements.

Conclusion

Effective enforcement of mental health and substance use disorder parity laws requires regulators to move beyond isolated fines toward comprehensive enforcement strategies. By implementing robust corrective action plans, meaningful financial penalties, contracting requirements, consumer restitution mechanisms, and other innovative enforcement tools, states can make consumers whole and create real incentives for health plans to achieve and maintain parity compliance. Ultimately, these enforcement actions must focus on ensuring that consumers can access the mental health and substance use disorder services they need without discriminatory barriers.

Appendix

I. Ensuring Consumers are Made Whole

Sample Legislative Text for Mandatory Reprocessing of Improperly Denied Claims

Mass. Gen. Laws tit. 2 ch. 26 § 8K (c).

If a violation of state laws related to mental health and substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-26, as amended, and federal guidance or regulations issued under the act, was likely to have caused denial of access to behavioral health services, the commissioner shall require carriers to provide remedies for any failure to meet the requirements of state laws related to mental health and substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-26, as amended, and federal guidance or regulations issued under the act, which may include, but shall not be limited to:

> *(i) requiring the carrier to change the benefit standard or practice, including updating plan language, with notice to plan members;*
>
> *(ii) providing training to staff on any changes to benefits and practices;*
>
> *(iii) informing plan members of changes;*
>
> *(iv) requiring the carrier to reprocess and pay all inappropriately denied claims to affected plan members, notify members of their right to file claims for services previously denied and for which members paid out-of-pocket and reimburse for services eligible for coverage under corrected standards; or*
>
> *(v) requiring the carrier to submit to ongoing monitoring to verify compliance.*

Sample Legislative Text for Including Private Rights of Action in State Law

(a) Notwithstanding federal law, any person—including beneficiaries, providers, or designated representatives—aggrieved by an insurer's violation of state mental health

parity laws may bring suit in state court for:

(1) declaratory and injunctive relief;

(2) restitution of wrongfully denied benefits;

(3) recovery of civil penalties and reasonable attorney's fees.

Sample Legislative Text for Temporarily Suspension of Plan Offerings

(a) Upon finding that an insurer or carrier has materially violated mental health parity requirements, the [insurance regulator] may, after notice and opportunity to be heard, temporarily suspend:

(1) the filing or issuance of new policy forms;

(2) marketing, enrollment, or renewal of products in the non-federal group or individual market; until such time as the Commissioner finds that the insurer has implemented required corrective actions and is in compliance with parity laws.

(b) During suspension, the insurer shall continue servicing existing enrollees, including processing claims, but is prohibited from adding new members in this jurisdiction.

II. Sample Penalties and Fines

Connecticut Substitute Bill No. 10, Sec. 4:

(a) (1) The commissioner, after providing an opportunity for a hearing in accordance with chapter 54 of the general statutes, may impose a civil penalty on any health carrier of not more than one hundred dollars with respect to each participant or beneficiary covered under a health insurance policy of such health carrier, provided such penalty shall not exceed an aggregate amount of one million dollars annually, for such health carrier's failure to comply with the certification requirements pursuant to the provisions of section 1 of this act, or the state and federal mental health and substance use disorder benefit reporting requirements identified in subdivision (1) of subsection (b) of section 1 of this act.

(2) The commissioner may order the payment of such reasonable 80 expenses as may be necessary to compensate the commissioner in conjunction with any proceedings under this section, which shall be dedicated to the enforcement and implementation of the state and federal mental health parity laws and regulations adopted thereunder.

(b) (1) If any health carrier fails to file any data, report, certification or other information required by the provisions of section 38a-477ee of the general statutes, as amended by this act, or section 1 of this act, the commissioner shall impose a late fee on such health carrier of one hundred dollars per day from the due date of such filing of data, report, certification or information to the date such health carrier submits such filing to the commissioner.

(2) For any health carrier that files any incomplete data, report, certification or other information required by the provisions of section 38a-477ee of the general statutes, as amended by this act, and section 1 of this act, the commissioner shall provide notice to such health carrier of such incomplete filing that includes (A) a description of such data, report, certification or other information that is incomplete and any additional data that is needed to consider such filing complete, and (B) the date by which such health carrier is required to provide such data. The commissioner shall impose a late fee on such health carrier of one hundred dollars per day, commencing from the date identified by the commissioner pursuant to subparagraph (B) of this subdivision.

(c) The commissioner may waive any civil penalty imposed pursuant to subsection (a) of this section if the commissioner determines that the violation was due to reasonable cause and was not due to wilful neglect, or if such violation is corrected not more than thirty days after the date that the health carrier filed a certification of noncompliance with the commissioner pursuant to section 1 of this act.

(d) All civil penalties and late fees received by the commissioner pursuant to this section shall be deposited in the General Fund and credited to the parity advancement account established pursuant to section 3 of this act.

Pennsylvania Article VI-B:

(a) General rule.--Upon satisfactory evidence of a violation of this article by any insurer or other person, the commissioner may, in the commissioner's discretion, pursue any one of the following courses of action:

(1) Suspend, revoke or refuse to renew the license of the offending person.

(2) Enter a cease and desist order.

(3) Impose a civil penalty of not more than $5,000 for each action in violation of this article.

(4) Impose a civil penalty of not more than $10,000 for each action in willful violation of this article.

(b) Limitation.--Penalties imposed against a person under this article and under section 5 of the act of June 25, 1997 (P.L.295, No.29), known as the Pennsylvania Health Care Insurance Portability Act, shall not exceed $500,000 in the aggregate during a single calendar year.

Mass. Gen. Laws tit. 2 ch. 26 § 8K(b):

The commissioner may impose a penalty against a carrier that provides mental health or substance use disorder benefits, directly or through a behavioral health manager as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, for any violation by the carrier or the entity that manages or administers mental health and substance use disorder benefits for the carrier of state laws related to mental health and substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-26, as amended, and federal guidance or regulations issued under the act.

The amount of any penalty imposed shall be $100 for each day in the noncompliance period per product line with respect to each participant or beneficiary to whom such violation relates; provided, however, that the maximum annual penalty under this subsection shall be $1,000,000; provided further, that for purposes of this subsection, the term "noncompliance period" shall mean the period beginning on the date a violation first occurs and ending on the date the violation is corrected.

A penalty shall not be imposed for a violation if the commissioner determines that the violation was due to reasonable cause and not to willful neglect or if the violation is corrected not more than 30 days after the start of the noncompliance period.

III. Disallowance of Products

Rhode Island: RI Gen L § 27-2.6-19. (2024) Penalties and liabilities:

(a) If the commissioner determines that the title insurer has violated this chapter, or any regulation or order promulgated thereunder, after notice and opportunity to be heard, the commissioner may order:

(1) A penalty pursuant to § 42-14-16 for each violation; and

(2) Revocation or suspension of the title insurer's license.

(b) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance code.

(c) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and creditors.

Sample Legislative Text for Graduated Enforcement before Disallowance

Section X. Product Disallowance for MHPAEA Noncompliance

(a) Graduated Enforcement Authority.

(1) The Commissioner shall adopt a tiered enforcement structure for mental health parity compliance, applicable to all carriers and health care products authorized for sale in this State.

(2) The tiered structure shall include, at a minimum:

(A) Tier 1 – Corrective Action Order: Issued upon a first finding of noncompliance, requiring remedial action within a defined period and accompanied by technical assistance where appropriate.

(B) Tier 2 – Monetary Penalties and Enhanced Oversight: Applied for repeated noncompliance or failure to remedy deficiencies identified in a Tier 1 order; includes increased reporting obligations, independent auditing, and penalties consistent with § XX-XX.

(C) Tier 3 – Product Disallowance: Applied for severe or repeated noncompliance that substantially impairs access to MH/SUD benefits. The Commissioner may suspend, revoke, or prohibit the marketing, sale, or renewal of the noncompliant product(s) until full compliance is demonstrated.

(b) Transparent Compliance Process.

(1) The Commissioner shall establish and publish clear criteria defining the circumstances under which each enforcement tier will be applied, including factors such as severity, duration, and consumer impact of the violation(s).

(2) Carriers subject to enforcement actions shall receive written notice specifying the violations, required corrective measures, and applicable timelines.

(3) Carriers may petition for reinstatement of disallowed products by submitting a compliance remediation plan, verified by independent audit, demonstrating that

all violations have been remedied.

(4) The Commissioner shall review reinstatement petitions within 60 days and may condition reinstatement on ongoing monitoring and periodic reporting.

(c) Consumer Protection Priority.

In all cases, the Commissioner shall prioritize consumer protection, access to MH/SUD care, and restoration of compliant benefits when determining whether to disallow products or reinstate previously disallowed products.

IV. Contracting Requirements

The Ohio Department of Medicaid Provider Agreement for Managed Care Organizations (2025):[20]

8. Mental Health Parity and Addiction Equity Act (MHPAEA) Requirements

a. The MCO must comply with Mental Health Parity and Addiction Equity Act requirements outlined in 42 CFR Part 438 Subpart K, with regard to services provided to managed care members. The requirements apply to the provision of all covered benefits and additional services (i.e., value-added and in lieu of services) to all populations included under the terms of this Agreement.

i. The MCO must participate in ODM-requested meetings, respond to ODM information requests, work with ODM to resolve compliance risks, and notify ODM of any changes to benefits or limitations that may impact compliance with MHPAEA.

ii. The MCO must conduct ongoing monitoring to determine compliance with MHPAEA and report compliance analysis and determinations using the MHPAEA Compliance Assessment Tool (MHPAEA Tool) provided and required by ODM.

iii. The MCO must submit an updated MHPAEA Tool and written attestation of MHPAEA compliance to ODM:

1. *At least 30 calendar days prior to the proposed effective date for implementing any new clinical coverage policy or changes to previously approved clinical coverage policies;*
2. *At least 30 calendar days prior to the proposed effective date to apply a financial requirement (co-payment);*

3. *At least 30 calendar days prior to the effective date of a change to benefits or limitations that may impact MHPAEA compliance;*

4. *Annually, as specified in Appendix P, Chart of Deliverables; and*

5. *Upon ODM's request.*

iv. The MCO's annual updated MHPAEA Tool must include an annual summary of self-monitoring activities that describes:

1. *The MCO's processes for reviewing and analyzing changes to benefit packages, service delivery structures, operational requirements, and policies to ensure ongoing parity compliance; and*

2. *The MCO's processes for monitoring parity compliance in operation on a regular basis, including:*

    a. *The data/information monitored by the MCO to identify potential parity compliance concerns, the frequency of the MCO's review of the data/information;*

    b. *b. How the MCO determines when further analysis is necessary; and*

    c. *The process used by the MCO to conduct further analysis when the data/information suggests the possibility of a parity compliance concern.*

v. The MCO will work with ODM to ensure all members are provided access to a set of benefits that meets the MHPAEA requirements regardless of which behavioral health services are provided by the MCO.

V. Compliance Thresholds

Select language from California's Senate Bill 363, The Health Insurance Accountability Act, which was proposed in the 2025 legislative session,[21] and would amend the California Health and Safety Code 1374.38:

(a) (1) For each annual report submitted to the department by a health care service plan pursuant to Section 1374.37, the department shall compare the number of a health care service plan's treatment denials and modifications to both of the following:

(A) The number of successful independent medical review overturns of a health care service plan's treatment denials or modifications.

(B) The number of treatment denials or modifications reversed by the health care service plan after an independent medical review for the denial or modification is requested, filed, or applied for.

(2) (A) If more than 50 percent of a health care service plan's independent medical reviews result in an overturning or reversal of a treatment denial or modification in any one individual category enumerated in paragraph (1) of subdivision (a) of Section 1374.37, the health care service plan is in violation of this section and liable for an administrative penalty pursuant to subdivision (b). A health care service plan may be liable for multiple violations per annual report.

(B) Each independent medical review resulting in an additional overturned or reversed denial or modification in excess of the threshold described in subparagraph (A) constitutes a separate violation of this section.

(C) For purposes of this section, an independent medical review results in an overturning or reversal of a treatment denial or modification any time a treatment denial or modification is overturned or reversed after an independent medical review is requested, filed, or applied for, regardless of whether a determination is made by an independent medical review organization or health care service plan.

(b) A health care service plan that violates this section, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than twenty-five thousand dollars ($25,000) for the first violation, and of not less than fifty thousand dollars ($50,000) nor more than two hundred thousand dollars ($200,000) for the second violation, and of not less than five hundred thousand dollars ($500,000) for each subsequent violation.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

(d) Commencing January 1, 2031, and every five years thereafter, the penalty amounts specified in this section shall be adjusted to reflect the percentage change in the calendar year average, for the five-year period, of the medical care index of the Consumer Price Index, as published by the United States Bureau of Labor Statistics.

References

1 In some states, CMS is responsible for MHPAEA enforcement. In 2023, CMS was responsible for enforcement of MHPAEA for insurers in Texas and Wyoming, and six states (Alabama, Florida, Louisiana, Montana, Oklahoma, and Wisconsin) had collaborative agreements with CMS where the state performs regulatory and oversight functions but refers matters to CMS for possible enforcement action if the state is unable to obtain compliance. **https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf**.

2 42 U.S.C. 300gg-26(a)(8)(A).

3 **https://www.commonwealthfund.org/publications/issue-briefs/enforcing-mental-health-parity-state-options-improve-access-care**.

4 42 C.F.R. § 438.920(b)(2) (for managed care organizations, including when some benefits are delivered to enrollees in managed care plans through other delivery systems such as fee-for-service Medicaid); 42 C.F.R. § 440.395(e) (for alternative benefit plans); 42 C.F.R. § 457.496(f).

5 42 C.F.R. § 438.920(b)(1).

6 **https://pmc.ncbi.nlm.nih.gov/articles/PMC10953802/**.

7 Not all states give their Office of the Attorney General the authority to regulate health insurance plans as a consumer product, which may limit their ability to enforce MH/SUD parity and other similar laws. States without this statutory authority may wish to consider amending their laws to better protect their residents from insurance-related discrimination.

8 **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022**.

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16 https://law.justia.com/codes/rhode-island/title-27/chapter-27-2-6/section-27-2-6-19.

17 42 CFR § 438.915 and § 438.920

18 CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder parity Requirements, US Health and Human Services Office of Inspector General Report (A-02-22-01016), March 2024

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20 https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/2025_02_MCO_Final.pdf

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