



**SUPPLEMENT**  
**Mental Health Parity in Rhode Island-**  
**Experiences of patients and professionals:**  
*Focus on diverse consumer experiences*

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## **About the RI Parity Initiative**

The Mental Health Association of Rhode Island's RI Parity Initiative (Initiative) aims to increase public awareness about a patient's right to equal insurance coverage for services and treatment of mental illness, including addiction disorders, and to develop recommendations to expand and improve parity for all patients<sup>1</sup>.

## **Background**

In May 2019, the Initiative released 'Mental Health Parity in Rhode Island: Experiences of patients and professionals. (Report)<sup>2</sup> The Report highlights a set of common themes that emerged in focus group conversations with both consumers and providers relative to their experiences in Rhode Island's behavioral health system. This paper is an addendum to that report.

As described in the Report, there is a documented history of insurers erecting barriers to accessing behavioral health services for a range of conditions. These barriers violate mental health parity laws.<sup>3</sup> Since the release of the Report, the Rhode Island Office of Health Insurance Commissioner (OHIC) has completed an additional three market conduct exams on insurers operating in Rhode Island. These exams found all three insurers "non-compliant (with existing law) in certain aspects of their processes for approving coverage of behavioral health services—known as utilization review (UR).<sup>4</sup> In their review of United Healthcare, OHIC found that utilization review criteria used by review staff "were not based on objective, measurable, clinical criteria" and instead "relied on subjective vague and generalized conclusions or judgments."<sup>5</sup>

## **Goals**

The priority for the round of focus groups in this paper is to address limitations in the Report, specifically the inclusion of consumers with a wider range of immigration, racial, and ethnic backgrounds and diverse mental health experiences. The focus groups were established to hear directly from consumers about their (1) understanding of mental health parity, (2) experiences in getting adequate coverage for behavioral health services and treatment, (3) systemic barriers to accessing appropriate care and (4) broader experience of social stigma associated with mental illness.

The overarching goal of the Initiative's use of focus groups is to help shape a broader understanding of mental health parity issues in Rhode Island and to incorporate the voices and ideas of patients and professionals to achieve real parity in coverage of behavioral health services.

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<sup>1</sup> The Mental Health Parity and Addiction Equity Act (aka, Parity Law) requires health insurance plans that offer behavioral health benefits to do so no less restrictively than medical/surgical benefits.

<sup>2</sup> FINAL RI Parity Focus Group Report--Experiences of patients and professionals

<sup>3</sup> FINAL RI Parity Focus Group Report--Experiences of patients and professionals

<sup>4</sup> OHIC Releases Two Market Conduct Exams for Behavioral Health Coverage. ohic.ri.gov <http://www.ohic.ri.gov/documents/2020/March/Tufts-NHPRI MCE Press Release.pdf>.

<sup>5</sup> United Healthcare agrees to pay state \$350k, contribute \$2.85million to mental health fund. ohic.ri.gov. <http://www.ohic.ri.gov/documents/2020/March/United/United> Healthcare agrees to pay state \$350k, contribute \$2.85million to mental health fund.pdf

## Design

- Three groups were facilitated with a total of 22 consumer participants (one Spanish and two English language). Consumers were defined as patients, parents or family members.
  - One group of participants also served as certified community health workers. We found, across these groups, there were blurred roles that participants played. Specifically, many participants were both consumers of mental health care and facilitators of care for others through their work as community health workers, language interpreters, etc..
- Local Rhode Island non-profit organizations advertised the focus groups among their constituencies to recruit participants.
- Each group was facilitated by at least 1 lead facilitator, with at least one note-taker and were audio recorded verbatim for transcription. The Spanish language group was transcribed in Spanish and then translated into English.

**Limitations:** A limitation in this round of groups is that, because our goal focused on gaining an understanding from a more diverse patient population, we still have work to do to facilitate conversations with a more diverse provider population. Additionally, the heightened awareness of systemic racism affecting these communities and their access to care was outside the scope of this research but is a critical issue that should be addressed in future research.

## Findings

The results from the three focus groups yielded several recurrent themes, including:

1. The importance and often difficulty of finding a provider that you can connect with and trust.
2. Language and cultural barriers to mental health treatment.
3. Experiences of stigma, particularly concentrated in older generations and rooted in gender/cultural norms, preventing individuals from seeking/continuing mental health treatment.
4. The importance of family members as mental health advocates, and the difficulty of helping loved ones get and maintain treatment due to denial of mental health problems.
5. Insurance cost and coverage or lack thereof as a barrier to accessing mental health treatment.
6. Frustrating and time consuming experiences leading to a desire for systemic changes to make mental health care more accessible.
7. The need for more education about mental health, mental health parity, and navigating the mental health care system particularly for emergency providers, community health workers, refugees, and family members.
8. Some positive experiences with providers and support groups.

Several of these themes reflect findings from the May 2019 report, including general experiences of social stigma, difficulty finding a trusted provider, frustration and time consuming experiences with insurers, among others. However, certain distinct issues stand out, including the significant challenge of language and cultural barriers to treatment and the challenges faced by refugee and immigrant community members related to 'learning' new systems of coverage and care and the need for help in navigating them. A more comprehensive summary of each theme is presented in the subsequent subsections.

## **The importance and difficulty of finding a provider that you can connect with and trust.**

Research supports the importance of the patient-clinician relationship in mental health care. A recent article published in the *Psychiatric Services* journal found that in the patient-clinician relationship feelings of trust in particular are critical to the therapeutic process. Those who had difficulty establishing mutual trust or who had experienced a breach of trust with their mental health clinicians described it as a barrier to therapy<sup>6</sup>.

Individuals in all of the focus groups also stressed the importance of trust in their relationships with their providers. One participant noted “If I can’t trust the person that I am talking to, because I am telling that person things that have never come out of my mouth, I haven’t talked to anyone about them, so at least for me, when I met here at the beginning, she looked at me, I looked at her, and when she came in, I thought, who is she? Can I trust her? If I can’t talk openly and clearly, it’s not worth me coming here because if I don’t trust her, I won’t receive the treatment.”(Group 3)

Participants also talked about the difficulty and sometimes time-consuming nature of establishing this level of trust with a particular provider. “Trying to find a therapist for myself that I can relate to has been, now, a six-month search.”(Group 1)

These focus groups also revealed how trust issues may be compounded in minority and immigrant communities. A community health worker participant who works primarily with refugees made the point that many of their clients struggled to fully trust the mental health provider due to cultural differences with the health care system. “In his community, they don’t have same like this procedure. They gonna ask him very personal questions. Yeah. Most of these people, they are shy to tell them... We try to make them trust the doctor and all the people they work with.” (Group 2)

## **Language and cultural barriers to mental health treatment.**

Cultural and language barriers further complicate the cultivation of trust between patient and providers and navigation of a complex and fractured healthcare system. Network inadequacy was addressed in the first round of focus groups, and those who speak little or no English are likely to face even more challenges finding a reliable provider within their insurance network.

One participant said “We always say the big difficult, the big challenge, and the first challenge for all the refugee is the language.” (Group 2) Another participant notes that it is not just language, but culture as well, that can affect treatment outcomes for ethnic minority and immigrant patients. “How do we trust the young providers? Culturally, will they understand? They may speak the language, but culturally, do they understand where we come from and what other people...have gone through?”(Group 1)

Research also confirms that low English language proficiency, cultural values, and low levels of acculturation act as barriers to seeking help. A 2011 study titled *Cross-Cultural Barriers to Mental Health Services in the United States* found that language difficulties can be particularly challenging for recent immigrants from Spanish-speaking and Asian countries, who may be less likely to enter and stay in treatment due to lack of understanding. The authors also found it

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<sup>6</sup> Cromer, Risa, et al. "Trust in mental health clinicians among patients who access clinical notes online." *Psychiatric Services* 68.5 (2017): 520-523.

difficult to separate the effect of low English language proficiency from the influences of cultural values and acculturation.<sup>7</sup>

Unfortunately, there is a scarcity of both bilingual and bicultural mental health providers in the United States. For example, in a 2015 nationwide American Psychological Association survey, only 5.5 percent of psychologists said they could provide services in Spanish, making them a rare commodity.<sup>8</sup>

### **Experiences of stigma, particularly that which is concentrated in older generations and rooted in gender/cultural norms, preventing individuals from seeking/continuing mental health treatment.**

Stigma includes both prejudicial attitudes and discriminating behavior towards individuals with mental health conditions. The social effects of this include exclusion, poor social support, poorer subjective quality of life, and low self-esteem<sup>9</sup>. Social stigma regarding mental illnesses and their treatment protocols is present within personal and professional settings, such as families, schools, and occupations. All of the focus groups discussed the presence of stigma as a factor that influences not only how mental health is viewed and treated by others, but how they view their own mental health as well.

One participant said, “Due to where I grew up and the way I was raised, there is a stigma around mental health. If I have a condition, it is immediately associated with my value, and I am not the illness, and it has taken...many years for me to understand that I am not bipolar, that I suffer from a bipolar condition, but I am not it.” (Group 3)

**“I suffer from a bipolar condition, but I am not it.”**

This external and internal stigma appears to be shaped by additional characteristics such as gender, age, and culture. It is well documented that men experience greater personal stigma around mental health than women, making them far less likely than women to seek mental health treatment. Often, the main source of stigma in men is tied to gender norms concerning masculinity. Men have received the message from society that they are expected to be strong at all times, and thus they learn to suppress their emotions<sup>10</sup>. One participant shared how men in her home country of Brazil are expected to remain strong no matter the circumstances. “In Brazil, you might break something, but the tough guy thing to do is to not go to the doctor and to be tough and to show your scars.” (Group 1) Another participant adds that men will likely avoid mental health treatment out of embarrassment. “They [men] will be embarrassed, and they’re not gonna get to that. They’re gonna get drunk, or they’re gonna get high—just how it is—and not say, “Okay, I have a problem. I need to go to the doctor because there’s something wrong with me.”(Group 1)

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<sup>7</sup> Leong, Frederick T L, and Zornitsa Kalibatseva. “Cross-cultural barriers to mental health services in the United States.” *Cerebrum: the Dana forum on brain science* vol. 2011 (2011): 5.

<sup>8</sup> Hamp, Auntré, et al. “2015 APA survey of psychology health service providers.” (2016)

<sup>9</sup> Livingston, James D., and Jennifer E. Boyd. “Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis.” *Social science & medicine* 71.12 (2010): 2150-2161.

<sup>10</sup> Winerman, Lea. “Helping Men to Help Themselves.” *PsycEXTRA Dataset*, 2005. <https://doi.org/10.1037/e408882005-035>.

Generational differences also play a significant role in how individuals experience and internalize stigma. In the first round of focus groups, primarily Caucasian, participants highlighted a perceived reduction of stigma among millennials and younger people. This round of focus groups additionally recognizes the role that one's cultural background plays in influencing social stigma across generations. For example, one participant tied the generational discrepancy in mental health acceptance in her own family to experiences growing up in another country versus growing up in the United States. "We were born here. We grew up in America. The way we were brought up is Americanized, I would say, so it's a lot different. A lotta the things, I guess, that are normal for us aren't normal for our parents." (Group 1)

### **The importance of family members as mental health advocates, and the difficulty of helping loved ones get and maintain treatment due to denial of mental health problems.**

The focus groups revealed that it was relatively common for individuals to act as mental health advocates for a family member, or for a family member to play a significant role in their own mental health journey. One participant gives the specific example of how her brother played an important role in her decision to seek treatment for her bipolar disorder. "When I came here (to local behavioral health center) at the beginning, I didn't want to accept that I was sick. For me, I was normal, but my brother who always watches out for me would say 'look, you have to accept that you are sick, that you aren't okay'...my brother started to investigate how I could help myself, he started to look on the Internet what the pros and the cons of the bipolar program were, and how he could help me to get better." (Group 3)

Some family members serving as advocates voiced confusion over how best to help their family members. They also felt frustrated when their loved ones denied mental health conditions or refused to follow through with treatment. One participant summed up this experience by saying "if somebody's the person, who needs the help, isn't helping get the appointments and stuff—not keeping them—that's where the frustration lies for the loved ones." (Group 1)

Another participant noted that over time the stress and frustration of caring for a loved one struggling with mental illness can have negative consequences for the mental health of other family members as well. "Sometimes it almost feels as if mental illness—I know it's not contagious, but dealing with somebody who's mentally ill and going up and down feels like, maybe, I'm the one who's crazy 'cause he seems to be enjoying himself. It's frustrating because I'll make appointments, and he can blow them off. Then, when he's really down, I've gotta take over and literally put him in the car and bring him and answer the questions." (Group 1)

### **Insurance cost and coverage or lack of coverage as barriers to accessing mental health treatment.**

All focus groups expressed some level of dissatisfaction with the cost of their insurance and/or the coverage they received. Similar to the first round of focus groups, participants faced restrictions in the providers they were able to see as a part of their insurance network and difficulties getting their insurance company to cover needed treatment services.

One participant described the struggle of getting insurance coverage for her family member's schizophrenia injections. "That medication, it's like—there was a copay. He has Medicare and part A, part D—a whole process. There's hoops to jump through." (Group 1) These hurdles are

likely a part of the increasing drug restrictions characterizing Medicare part D coverage. Specific restrictions include: prior authorization, step therapy, and quantity limits.<sup>11</sup>

Focus group participants also experienced what many Americans face: earning too much money to qualify for public insurance (Medicaid) but being unable to comfortably afford private coverage. Additionally, many discussed the difficult financial decision of having to choose between paying for mental health treatment and other necessary purchases such as rent or food. For example, a participant shared her personal experiences of trying to balance her insurance co-payment with other essential purchases; “I am going to make the decision, I pay the rent or I pay the electricity or I buy clothes or I buy toilet paper or the treatment.” (Group 3)

Unfortunately, these struggles are not unique. A recent survey revealed more than half of Americans surveyed want mental health services either for themselves or for a loved one, but about three-quarters said there are access issues, with 34% pointing to cost. One in four reported having to choose between getting mental health treatment and paying for daily necessities<sup>12</sup>. These struggles can be further exacerbated in minority communities, where individuals are more likely to be underinsured and face financial difficulties.

### **Frustrating and time consuming experiences leading to a desire for systemic changes to make mental health care more accessible.**

Many individuals complained about the time it took for them to be able to access the care that they needed. One participant described the long trip she had to make to get to her appointments at a local mental health center. “I take two buses to come and two buses to go back.”(Group 3) Others complained of long wait times of up to a month to see a specialist. As one participant pointed out “when people come to an appointment for the first time, the appointments are given far in advance and sometimes they need an emergency, faster.” (Group 3)

Some community health workers felt that they did not have enough time to adequately serve the needs of their clients. A participant explained, “They [clients] need more services from us. We... are not full-time workers here. We have our own life where we are doing something outside...we have to work for our family too. We don’t have really...enough time to work with them. The real time we have, we do our best to help.” (Group 2)

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<sup>11</sup> Li D. Medicare Part D in 2020: Higher Enrollment, Less Coverage, More Restrictions - GoodRx. The GoodRx Prescription Savings Blog. <https://www.goodrx.com/blog/medicare-part-d-plans-in-2020-enrollment-coverage-costs-restrictions/>. Published April 10, 2020. Accessed June 4, 2020.

<sup>12</sup> America's Mental Health 2018. <https://www.cohenveteransnetwork.org/wp-content/uploads/2018/10/Research-Summary-10-10-2018.pdf>. Published October 10, 2018.

Among all the groups there was a desire for greater accessibility of mental health care. One participant simply said "That's what we need to work towards, easier access to have care—mental healthcare." (Group 1) Another proposed greater coordination between primary care and mental healthcare as a way to achieve this. "Why can't it be, in general, once a year that you could have mental healthcare [visit] that you could go and talk to somebody, even though, sometimes, you don't think you need it, but having the opportunity to sit down one-to-one with somebody that it could help you get out and say, "Yes, I do have this problem. Yes, I think I'm feeling this way." Having that access, I think, will be really good." (Group 1)

**"That's what we need to work towards, easier access to have care—mental healthcare."**

The desire for greater coordination between primary and mental health providers is also a theme that came up in the first round of focus groups, and the research supports this as well. Evidence consistently demonstrates collaborative care structures as providing better mental health outcomes than standard management in primary care settings. One meta-analysis specifically focused on patients with depression concluded that collaborative care is more effective than standard care in improving depression outcomes in the short and longer terms<sup>13</sup>.

### **The need for more education about mental health, mental health parity, and navigating the mental health care system particularly for emergency providers, community health workers, refugees, and family members.**

This research utilized the following working definition for the term mental health parity: "the set of federal and state laws that dictate equal health insurance coverage for mental health and substance use disorder services and treatment."

Unlike the first round of focus groups, where most participants had at least a basic understanding of the term, many in the second round of focus groups had little to no previous knowledge of mental health parity. When asked if they had heard the term before, many responded that they hadn't. This was the case for both consumers and community health workers that participated. One participant, when asked to define the term mental health parity, responded, "Yeah, actually, I am a freshman master's degree in mental health counseling. I haven't heard about that before." This is indicative of the need for wider education about mental health parity.

Another important need revealed in this round of focus groups is for greater resources to teach recent immigrants about navigating the health care system in the United States, which is likely very different than in their home country. On top of the stress and anxiety of moving to a new country and having to make major life adjustments, refugees also have the challenge of learning the complex health care system that we have in the United States. A participant who is also a community health worker and works with new refugees illustrated the long list of necessary information she has to go over with her clients. "At the beginning, we started to explain to him what's the procedure for medical here. How can they get all the appointments? How can they go [transportation]? We try to help them for the training, for make appointment. What's the

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<sup>13</sup> Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. *Arch Intern Med.* 2006;166(21):2314–2321. doi:10.1001/archinte.166.21.231

difference between the appointment and [an] emergency? What's the time they can call 911? There's a lot of information." (Group 2) It is also worth noting that many American-born patients do not fully understand the complicated structure of the American health versus out-of-network; copays; coinsurance; deductibles; and out-of-pocket maximums. One can only imagine how confusing these concepts must be to someone coming from another country with a radically different healthcare system.

Finally, participants emphasized the need for greater education about mental health for community members in order to reduce stigma. For example, one participant recalled her experience in facing stigma from her family for her depression and said "...well, I know they aren't saying it to me to be evil but it is the lack of knowledge they have, when they say to me, 'Why don't you just snap out of it?'" (Group 3) Another participant in the same group stressed the importance of beginning this education at an early age. "More education at an earlier age. Please, children aren't as ignorant as [people] think, they know a lot, they understand, if they are spoken to at a level that they can understand." (Group 3)

### **Some positive experiences with providers and support groups.**

While both the first and second round of focus groups revealed many experiences of frustration navigating the mental health care system, there were also examples of positive experiences that can be used to improve mental health care for others.

One participant who was in college described her experience accessing treatment as being very easy. "I'm in college, and, at my school, they offer free mental health counseling. It was easy for me to find that and go to them, make an appointment and meet with them every week. After that, I got a referral from my actual doctor to see another therapist closer to home, so just getting that referral and making an appointment was really easy for me." (Group 1)

Her specific experience with her therapist also highlights the benefits of culturally competent care. "The person that I'm seeing now, I really like talking to them. Even though they're not of the same ethnic background, they understand where I come from, what I'm trying to tell them. They wanna learn more about it so they can understand me better."

Individuals at a local health center had overwhelmingly very positive experience with their therapists and support groups. A participant said, "The treatment has been very good and excellent for me. I was able to find someone that I can sit with and talk to her and that person meets me where I am." (Group 3) Another emphasized the importance of the support she receives not just from her providers, but also from others with shared mental health experiences. "It is also very important that we all have a group of women, and we all support each other, and that's very important, because it's not just in the group, but also outside the group, we are supporting each other."(Group 3)

Many studies document the importance of social support, and one literature review studying support groups in particular found that there is a consistent pattern of evidence, over a long period of time, confirming the effectiveness of mental health support groups for caregivers and people living with mental illness<sup>14</sup>.

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<sup>14</sup>Worrall, Hugh, et al. "The effectiveness of support groups: a literature review." *Mental Health and Social Inclusion* (2018).

## Conclusion/Recommendations

In addition to issues of network inadequacy and social stigma commonly experienced by the general population, these focus groups highlight important cultural disparities occurring in mental health care in Rhode Island. The landmark report *Culture, Race, and Ethnicity* documented the lack of access and poor quality of mental health care among minorities—patients are less likely to receive diagnosis and treatment for a mental illness, less likely to get help, and are more likely to die by suicide<sup>15</sup>. As the ethnocultural diversity within the US and Rhode Island continues to grow, we have a societal responsibility to address these disparities.

Therefore, in addition to the recommendations published in the RIParity May 2019 report, we also recommend the following to help Rhode Island move mental health parity for every resident in our state from aspiration to reality:

- **Strengthen standards for and monitoring of cultural competence that are clearly articulated in agreements between funding agencies and providers.** It's important to note that while work has been done to incorporate National CLAS<sup>16</sup> standards in health plans and the state's healthcare system, much more must be done, including:
  - Mandate ongoing cultural competence training for clinicians and others who provide public mental health services and supports.
  - Incorporating cultural sensitivity of providers as an outcome measure tracked by the state using the SAMHSA uniform reporting system, as is currently done by 47 other states.
  
- **Invest in expanding the network of bilingual/bicultural providers throughout Rhode Island's existing behavioral health network:**
  - Minimize the shortage of minority and bilingual providers by incentivizing minority and bilingual students to enter Behavioral Health professions, including the following recommendations to recruit and retain a more ethnically and racially diverse student enrollment in academic and training programs:
    - Reduce reliance on, or suspend required standardized testing, including ACT/SAT and the GRE, which have been shown to be biased in favor of the majority White student population.
    - Establish or expand services intended to support and retain minority students.
    - Expand practicum experiences for students interested in working with diverse populations by broadening the network of community organizations and local agencies the college/university partners with.
    - Diversify faculty in behavioral health academic programs, including by documenting specific recruitment strategies and changes to research and tenure policies intended to identify and address systemic racism and bias in current practices<sup>17</sup>.
  - Invest in strengthening and building bilingual/bicultural assistance programs, such as teams of community health workers, that link the state's community mental health

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<sup>15</sup> Satcher D. Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. 2001. <http://www.ncbi.nlm.nih.gov/books/NBK44243>.

<sup>16</sup> Barksdale, Crystal L., et al. "Literature review of the national CLAS standards: policy and practical implications in reducing health disparities." *Journal of racial and ethnic health disparities* 4.4 (2017): 632-647.

<sup>17</sup> 1 NZN, 1 CTPauthorN, 21 NEF. Making the counseling profession more diverse. Counseling Today. <https://ct.counseling.org/2017/10/making-counseling-profession-diverse/>. Published October 25, 2017. Accessed June 24, 2020.

centers, hospitals, primary care practices, and other service providers with the Health Equity Zones, and the schools, places of worship, and community-based organizations in their communities that have direct contact with populations most marginalized in the current system.

- Target underserved populations by investing in incentivizing and expanding the state's network of bilingual community health workers, interpreters, and peer support specialists and adapting current certification training to build deeper understanding of behavioral healthcare among these workers.
- **Increase access to education about mental health and access to mental health services.**
  - Invest in mental health education as part of K-12 curriculum and invest in expanding access to mental health professionals in our schools, including social workers, guidance counselors, and school psychologists to be reimbursed by Medicaid.
  - Increase state funding for behavioral health system improvements and expansion – particularly for outpatient services -- and investment in efforts to change public attitudes about mental health designed to reach across all racial and ethnic groups.
  - Improve transparency by requiring insurers to prominently post benefit booklets, medical policies, definitions, and appeal processes on both their consumer and provider website portals. Their precise location should be disclosed to consumers and providers in writing on enrollment or within 30 days of the contract's start date and be linguistically accessible to all enrollees.

Appendix  
***Recommendations From 2019 Report***<sup>18</sup>

Based on the input from mental health patients and providers, combined with current research on behavioral health systems, we recommend the following to help Rhode Island move mental health parity in our state from aspiration to reality:

- Notification of consumers' rights as well as federal and state parity laws by insurers to consumers at enrollment and to providers within 30 days of a contract start date. It is further recommended that these informative materials be drafted in collaboration with the Health Insurance Commissioner and with patient/consumer advocacy groups as named by the Commissioner. In addition, such notifications should be written in easily understood wording and available in multiple languages.
- More frequent and detailed examinations by the Health Insurance Commissioner of compliance by insurers with non-quantitative parity requirements, especially for provider reimbursement, network adequacy, and patient cost sharing.
- Evaluate and mandate improvements in reimbursement rates through both Medicaid and commercial insurers to guarantee that:
  - Reimbursement rates as set are sufficient for coverage of needed services, and
  - Rates are sufficient to incentivize introduction of needed services that currently are not broadly available in Rhode Island.
  - Reimbursement to providers and consumers happens in a regular and timely fashion.
- More frequent review by the Health Insurance Commissioner of online provider directories for compliance with state and federal regulations, and development of an improved mechanism for consumers to report out-of-date information to the Health Insurance Commissioner.
- Removal by insurers of burdensome prior authorization and case management requirements that are not productive or are contrary to achieving parity.
- Simplify and standardize patient/provider authorization, claims, and appeals processes and improved transparency of plan benefits and restrictions.
  - A priority should also be that plan benefit changes, including drug formularies, should be restricted to the subscriber's renewal.
- Standardize treatment protocols, levels of treatment, and coverage limits for each mental illness, including substance use disorders, across insurers and plans. Treatment protocols, levels of treatment, and limits must be based on evidence and should utilize a variety of medical and mental health diagnostics, as determined by a group of mental health experts. No more than one-third of these mental health experts may be employed by, or contracted with, public or private insurers.
- Increase state funding for behavioral health systems improvements and expansion – particularly for outpatient services -- and investment in efforts to change public attitudes about mental health.

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<sup>18</sup>[FINAL RI Parity Focus Group Report--Experiences of patients and professionals](#)

- Scale up integration of primary and behavioral health practices for better coordination and to allow for better preventative and intermediate behavioral health delivery.
  - Most particularly address improvements in treatment and integration of behavioral health care in hospital emergency rooms to improve patient experience and treatment protocols, as well as to better divert treatment to more appropriate settings
- Improve transparency by requiring insurers to prominently post benefit booklets, medical policies, definitions, and appeal processes on both their consumer and provider website portals. Their precise location should be disclosed to consumers and providers in writing on enrollment or within 30 days of the contract's start date.

Expand prevention and wellness incentives, such as gym memberships, to include mental health focused activities suc