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The Shortcomings of Mental Health and Substance Use Disorder Parity and Opportunities for Improved Enforcement

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THE SHORTCOMINGS OF MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY AND OPPORTUNITIES FOR IMPROVED ENFORCEMENT

MADELEINE LAROCK*

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I. INTRODUCTION

Federal and state laws developed the concept of mental health ("MH")[1] and substance use disorders ("SUD") parity,[2] which requires that health insurers cover MH/SUD at an equivalent level to medical and surgical ("med/surg") coverage.[3] However, true

1. While some organizations have distinguished between mental health conditions/disorders and mental illnesses, this article will use these terms interchangeably. *See, e.g.*, *Mental Health vs. Mental Illness: The Difference and Why It Matters*, TAYLOR COUNS. GRP. (June 18, 2021), www.taylorcounselinggroup.com/blog/mental-health-vs-mental-illness [perma.cc/2QEJ-77AU] ("While mental health refers to anyone's state of mental, emotional well-being, mental illnesses are diagnosed conditions that affect thoughts and behaviors.").

2. *See Parity*, MERRIAM-WEBSTER, www.merriam-webster.com/dictionary/parity [perma.cc/W4MW-K5EJ] (last visited Oct. 6, 2022) (defining parity as "the quality or state of being equal or equivalent").

3. *See, e.g.,* 29 U.S.C. § 1185a (2013) (Federal Parity Law); 215 ILL. COMP. STAT. 5/370c (2021) (requiring health issuers to cover medically necessary treatment for MH/SUD beginning January 1, 2023, in the State of Illinois); 29 C.F.R. § 2590.712 (2015) (stating med/surg benefits are "benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but does not include mental health or substance use disorder benefits").

parity remains aspirational, as crucial coverage gaps have emerged and enforcement has proven exceedingly challenging.[4]

In one example, Jake Machovsky's family noted "[o]ur insurance halted our son's mental health care, and he paid with his life."[5] Jake Machovsky was just fifteen years old when he took his own life.[6] Prior to his death, Jake had been hospitalized twice within one month for suicidal ideations.[7] After his first hospitalization, instead of being transferred to an inpatient treatment program recommended by his doctors, he was transferred to an outpatient treatment program at the insistence of his insurance company.[8] The outpatient treatment program failed.[9] Jake was hospitalized for a second time.[10] His family and doctors knew he was not ready to return home.[11] Yet, his insurer refused to cover inpatient treatment until the same outpatient program failed for a second time.[12] Jake did not make it that long.[13]

"Not medically necessary."[14] Three words that shattered Jake and his family's lives forever.[15] Amid Jake's mental health crisis, his family appealed the issuer's decision, urging that insurance cover inpatient treatment.[16] The family faced mountains of paperwork with little guidance on where to start.[17] Jake died by suicide less than three months later.[18]

Had Jake suffered from a life-threatening physical condition,

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4. *See* discussion *infra* Section III.C, III.E.

5. *See* Denise Schatt-Denslow, *Our Insurance Halted Our Son's Mental Health Care, and He Paid with His Life*, ARIZ. REPUBLIC (June 20, 2022, 6:00 AM), www.azcentral.com/story/opinion/op-ed/2022/06/20/mental-health-services-should-up-doctors-not-insurers/7629980001 [perma.cc/W4DB-VG48] (telling the story of Jake Machovsky).

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *See Governor Ducey Signs Jake's Law, Improving Access to Mental Health Care*, ARIZ. GOV'T (Mar. 3, 2020), www.azcentral.com/story/opinion/op-ed/2022/06/20/mental-health-services-should-up-doctors-not-insurers/7629980001 [perma.cc/5BAX-YANN] [hereinafter *Jake's Law*] (providing another account of Jake Machovsky's story).

11. Schatt-Denslow, *supra* note 5.

12. *Id.*

13. *Id.*

14. *Id.*

15. *Jake's Law*, *supra* note 10.

16. Schatt-Denslow, *supra* note 5.

17. *Id.*

18. *See Jake's Law*, *supra* note 10 (noting that following Jake Machovsky's death, his parents were instrumental in drafting and passing "Jake's Law," an Arizona state parity law); *see also* Catherine Young, *Senate Passes "Timothy's Law" to Provide Mental Health Parity*, N.Y. STATE SENATE (Sept. 20, 2006), www.nysenate.gov/newsroom/press-releases/2006/catharine-young/senate-passes-timothys-law-provide-mental-health [perma.cc/DLN3-JUZ8] (noting that in New York, "Timothy's Law" was passed as a state parity law, brought forth by another family who lost their son to suicide).

as opposed to a mental health condition, his family believes he never would have been released from inpatient treatment.[19]

This article will analyze the gaps in federal and state parity law and opportunities for improved enforcement in the commercial insurance industry. Section II evaluates the prevalence of MH/SUD in the United States, the development of parity laws, and other considerations in parity law, such as the availability and affordability of health insurance and network adequacy. Section III analyzes the complexity and gaps in parity law, and recent enforcement findings and actions. Section IV provides recommendations for closing the gaps in parity law and improving parity enforcement.

Although legislators made laudable improvements toward ensuring equal treatment of MH/SUD coverage through state and federal parity laws, major coverage gaps remain. There are major discrepancies between the aspirations of parity laws and their true enforcement. Without a standardized enforcement method to ensure there is accountability of issuers and regulators, parity laws remain mere platitudes.

II. BACKGROUND

MH/SUD are among the most common health conditions in the United States.[20] This section will analyze the prevalence and impact of MH/SUD conditions on individuals in the United States. It will also evaluate the development of federal parity law, provide a high-level overview of state parity laws, and touch upon other factors that influence the effectiveness of parity laws.

A. Prevalence of MH/SUD in the United States

"A mental illness is a condition that affects a person's thinking, feeling, behavior or mood."[21] Substance use disorder is present when "the recurrent use of alcohol and/or drugs causes clinically

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19. Dennis Denslow, *Jake's Law: How the Memory of My Son is Driving Desperately Needed Change in AZ*, THE KENNEDY F. (Mar. 26, 2020), www.thekennedyforum.org/blog/jakes-law-how-the-memory-of-my-son-is-driving-desperately-needed-change-in-az [perma.cc/S6Q9-PKQ8].

20. *See* Kate Morgan, *These Are the Top 10 Health Conditions Affecting Americans*, USATODAY (Nov. 24, 2018, 5:15 PM), www.usatoday.com/story/sponsor-story/blue-cross-blue-shield-association/2018/10/24/these-top-10-health-conditions-affecting-americans/1674894002 [perma.cc/C9GZ-C7FR] (showing that four out of the top ten health conditions affecting Americans relate to MH/SUD, including major depression, substance use disorder, alcohol use disorder, and Psychotic Disorder).

21. *Mental Health Conditions*, NAT'L ALL. ON MENTAL ILLNESS, www.nami.org/about-mental-illness/mental-health-conditions [perma.cc/UP2F-83N7] (last visited Oct. 6, 2022).

significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[22] When both MH and SUD conditions are present, it is commonly referred to as a co-occurring disorder.[23] More generally, when multiple mental or physical health conditions are present, it is commonly referred to as a comorbidity.[24]

One in two people will develop a mental disorder within their lifetime.[25] In 2020, 21.0% of adults in the U.S. experienced a mental illness.[26] Additionally, 14.5% of adults were diagnosed with an SUD.[27] Of those diagnosed, 6.7% were diagnosed with co-occurring disorders (i.e., both an MH and SUD).[28] The presence of those suffering from comorbidity was even higher.[29] For example, the U.S. National Comorbidity Study found that 51% of patients diagnosed with major depression also had at least one anxiety disorder.[30] In sum, 29.3% of Americans had at least one MH and/or SUD condition in 2020, amounting to nearly 73.8 million people.[31]

Given the prevalence of MH/SUD in the United States, this section will evaluate the relationship between MH/SUD and

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22. *Mental Health and Substance Use Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., www.samhsa.gov/find-help/disorders [perma.cc/P5KA-SDH4] (last visited Oct. 4, 2022).

23. *Co-Occurring Disorders and Other Health Conditions*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/co-occurring-disorders [perma.cc/2Q5W-9RCD] (last visited Oct. 6, 2022).

24. Arlin Cuncic, *Comorbidities in Mental Health*, VERYWELL MIND (April 9, 2021), www.verywellmind.com/what-is-comorbidity-3024480 [perma.cc/5P64-BBZQ].

25. John J. McGrath et al., *Age of Onset and Cumulative Risk of Mental Disorders: A Cross-National Analysis of Population Surveys From 29 Countries*, THE LANCET 2 (Sept. 2023), www.sciencedirect.com/science/article/abs/pii/S2215036623001931 [perma.cc/VE2N-A7NH]; *Half of World's Population Will Experience a Mental Health Disorder*, HARVARD MED. SCH. (July 31, 2023), www.hms.harvard.edu/ news/half-worlds-population-will-experience-mental-health-disorder [perma.cc/L6NF-TEQK].

26. *Highlights for the 2020 National Survey on Drug Use and Health*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN. 2, www.samhsa.gov/data/sites/default/files/2021-10/2020_NSDUH_Highlights.pdf [perma.cc/YTA7-MRX7] (last visited Oct. 6, 2022) (defining adults as those aged eighteen or older). Of those diagnosed with a mental illness, 5.6% had a serious mental illness. *Id.*

27. *Id.* (stating that of those diagnosed with SUD, 28.3 million struggled with alcohol use, 18.4 million struggled with illicit drugs, and 6.5 million struggled with both alcohol and illicit drugs).

28. *Id.* (noting polysubstance use is also common—if an individual is struggling with one substance, they may be having similar struggles with other substances).

29. *See* Cuncic, *supra* note 24.

30. *Id.*

31. Miriam E. Delphin-Rittmon et al., *The National Survey on Drug Use and Health: 2020,* SAMHSA 7 (July 2022), www.samhsa.gov/data/sites/default/files/reports/slides-2020-nsduh/2020NSDUHNationalSlides072522.pdf [perma.cc/U2R9-E8WN].

physical health, the level of MH/SUD conditions that go untreated, the impacts of COVID-19 on the prevalence of MH/SUD conditions, and the negative stigma surrounding MH/SUD.

1. MH/SUD and Physical Health are Inextricably Bound

There is an undeniable link between MH/SUD and physical health.[32] Twenty-five percent "of patients admitted to a general hospital also have a behavioral health diagnosis."[33] Those living with depression have a forty percent higher risk of developing metabolic and cardiovascular diseases.[34] Further, those living with a serious mental illness are twice as likely to develop metabolic and cardiovascular diseases.[35] The risk of mortality for those with a mental illness is twice as high as the general population.[36] An estimated eight million deaths each year are attributable to mental illness.[37] As the World Health Organization ("WHO") has declared, "there is no health without mental health."[38] However, MH/SUD and physical health continue to be treated differently by healthcare professionals, insurers, and the general population. .

2. MH/SUD Conditions Remain Largely Untreated

Despite their prevalence, MH/SUD conditions go widely untreated.[39] In 2020, fifty-five percent of adults diagnosed with a

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32. *See* Karen Sowers et al., *The Intersection Between Physical Health and Mental Health: A Global Perspective*, J. EVIDENCE BASED SOC. WORK (Jan. 6, 2009), www.pubmed.ncbi.nlm.nih.gov/19199140 [perma.cc/PSH7-GW2D] ("Mental, physical, and social health are closely interwoven and interdependent.").

33. *AHA House Statement: America's Mental Health Crisis February 2, 2022*, AM. HOSP. ASSOC. (Feb. 2, 2022), www.aha.org/2022-02-03-aha-house-statement-americas-mental-health-crisis-february-2-2022 [perma.cc/2JEY-UYMG].

34. *Mental Health by the Numbers*, NAT'L ALL. ON MENTAL ILLNESS, www.nami.org/mhstats [perma.cc/CSY7-L4QJ] (last visited Oct. 6, 2022).

35. *Id.*; *see also About Mental Illness*, NAMI CAL., www.namica.org/what-is-mental-illness [perma.cc/NM3A-DFS5] (last visited Dec. 16, 2022) ("[S]erious mental health conditions include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), anxiety disorders, post-traumatic stress disorder (PTSD), and borderline personality disorder.").

36. Kathi Baker-Emory, *8 Million Deaths a Year Linked to Mental Illness*, FUTURITY (Feb. 12, 2015), www.futurity.org/mortality-mental-illness-855262 [perma.cc/5ADQ-LPL3].

37. *Id.*

38. *Health and Well-being*, WHO, www.who.int/data/gho/data/major-themes/health-and-well-being [perma.cc/MW5W-6LNZ] (last visited Sept. 12, 2022).

39. Maddy Reinert et al., *The State of Mental Health in America 2023*, MENTAL HEALTH AM. 21 (Oct. 2022) www.mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf [perma.cc/5NX7-P9XA].

mental illness did not receive treatment.[40] Further, even those who do seek MH/SUD treatment are often unable to receive the treatment they need.[41] In 2020, twenty-eight percent of adults with a mental illness faced barriers to receiving treatment.[42] The majority of those individuals (forty-two percent) reported they did not receive treatment because they could not afford it.[43] Other barriers included: (1) lack of knowledge on where to go for services; (2) mistaken belief that mental health was manageable without treatment; (3) lack of time to get treatment; and (4) lack of health insurance coverage.[44]

The rate of individuals with untreated SUD is even higher.[45] In 2020, ninety-four percent of adults reporting a SUD did not receive treatment.[46]

Untreated MH/SUD has devastating effects on an individual's livelihood.[47] Those with a severe mental illness are seven times more likely to be unemployed, and those with a common mental illness are three times more likely to be unemployed.[48] An estimated one-third of the homeless population in the United States is living with an untreated serious mental illness.[49] Twenty percent of inmates in jails and fifteen percent of inmates in state prisons live with a serious mental illness.[50] Overall, untreated mental illness costs the country an estimated $300 billion each year due to losses

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40. *Id.*

41. *Id.* at 22.

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.* at 16.

46. *Id.*

47. *See About Mental Illness*, *supra* note 35 ("Untreated mental health conditions can result in unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, and suicide, and poor quality of life.").

48. Evelien P.M. Brouwers, *Social Stigma is an Underestimated Contributing Factor to Unemployment in People with Mental Illness or Mental Health Issues*, BMC PSYCH. (April 21, 2020), www.bmcpsychology.biomedcentral.com/articles/10.1186/s40359-020-00399-0 [perma.cc/HK7Y-DDFX].

49. *Serious Mental Illness and Homelessness*, TREATMENT ADVOC. CTR. (Sept. 2016), www.treatmentadvocacycenter.org/wp-content/uploads/2024/01/smi-and-homelessness-2016.pdf [perma.cc/GJ5K-8UFB].

50. *See Serious Mental Illness Prevalence in Jails and Prisons*, TREATMENT ADVOC. CTR. (Sep. 2016), www.treatmentadvocacycenter.org/reports_publications/serious-mental-illness-prevalence-in-jails-and-prisons [perma.cc/RBM9-PZLS] ("The Los Angeles County Jail, Chicago's Cook County Jail, or New York's Riker's Island Jail each hold more mentally ill inmates than any remaining psychiatric hospital in the United States."); *see also* Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health*, PRISON POL'Y INITIATIVE (May 13, 2021), www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts [perma.cc/NRJ2-8PK6] (noting that incarceration is itself inherently harmful to people's mental health and worsened by the conditions of confinement).

in productivity.[51]

3. *COVID-19 has Heightened the Unmet Need for MH/SUD Treatment*

The COVID-19 pandemic has further "intensified the unmet need for services and has led to heightened difficulties for individuals with behavioral health conditions in accessing care."[52] During the period of April 2020 – April 2021, over 100,000 Americans died of overdose, a nearly thirty-percent increase from the previous year.[53] Additionally, by November 2020, the rate of anxiety in U.S. adults increased to fifty-percent and the rate of depression increased to forty-four percent, which is six times higher than early 2019 norms.[54] Some advocates have noted a minimal silver lining resulting from the pandemic, stating that "the inadequacy of mental health services has become undeniable, helping [build] momentum for parity."[55]

4. *There Remains a Negative Stigma Surrounding MH/SUD*

Finally, a negative stigma pervades MH/SUD.[56] Although more than one-third of Americans believe the stigma associated with mental illness has decreased over the last ten years, fifty-one

51. Daniel H. Gillison, Jr. & Andy Keller, *2020 Devastated U.S. Mental Health—Healing Must be a Priority*, THE HILL (Feb. 23, 2021, 2:01 PM), www.thehill.com/opinion/healthcare/539925-2020-devastated-us-mental-health-healing-must-be-a-priority [perma.cc/5Z8J-5628].

52. *America's Mental Health Crises*, AM. HOSP. ASS. (Feb. 2, 2022), www.aha.org/2022-02-03-aha-house-statement-americas-mental-health-crisis-february-2-2022 [perma.cc/ADR7-5PDT].

53. *2022 MHPAEA Report to Congress*, U.S. DEPT. OF LABOR, U.S. DEPT. OF HEALTH & HUM. SERV., AND U.S. DEPT. OF THE TREASURY 6-7 (2022), www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf [perma.cc/B7C3-48LD] [hereinafter *2022 Report to Congress*].

54. *See* Rebekah Levin Coley & Christopher F. Baum, *Trends in Mental Health Symptoms, Service Use, and Unmet Need for Services Among U.S. Adults Through the First 9 Months of the COVID-19 Pandemic*, TRANSLATIONAL BEHAV. MED. (Oct. 2021), www.doi.org/10.1093/tbm/ibab030 [perma.cc/Z57H-LRCW] (stating U.S. adults aged eighteen to twenty-nine saw the highest prevalence of anxiety and depression, with an anxiety rate of sixty-five percent and a depression rate of sixty-one percent by November 2020).

55. Don Sapatkin, *A Family's Struggle to Care for Son's Autism Reveals Gaps in Mental Health Parity Laws*, MIND SITE NEWS (Feb. 13, 2022), www.mindsitenews.org/2022/02/13/a-familys-struggle-to-care-for-sons-autism-reveals-gaps-in-mental-health-parity-laws [perma.cc/7Y4C-5QHN] [hereinafter *A Family's Struggle to Care for Son's Autism*].

56. *See* Wulf Rossler, *The Stigma of Mental Disorders*, EMBO REP. (Sept. 17, 2016), www.ncbi.nlm.nih.gov/pmc/articles/PMC5007563 [perma.cc/U7VK-UV6Z] ("There is no country, society or culture where people with mental illness have the same societal value as people without a mental illness.").

percent still believe individuals with a mental illness experience "a lot" of stigma and discrimination.[57] The negative stigma surrounding MH/SUD imposes irreparable harm to those living with MH/SUD conditions and negatively impacts their path to recovery.[58] It creates an avalanche of unfavorable consequences, including a reduced likelihood for seeking and receiving treatment, worsening symptoms, social isolation, a lack of understanding from family and friends, and fewer opportunities for work and school, among others.[59] On average, the delay between the onset of mental illness symptoms and treatment is eleven years.[60]

B. The Development of Federal Parity Law

The concept of parity dates back to 1961, when President John F. Kennedy directed the U.S. Civil Service Commission to require federal employee health plans to equivalently cover psychiatric illnesses with general medical care.[61] However, by 1975, health insurers were permitted to scale back their mental health coverage, and nearly all of them did.[62] As a result, throughout the 1970s and 1980s, dozens of state legislatures implemented parity requirements to improve private health insurance benefits.[63] In the

57. Jennifer De Pinto & Fred Backus, *Most Americans Think There is Stigma Associated with Mental Illness*, CBS NEWS (Oct. 23, 2019, 7:33 AM), www.cbsnews.com/news/most-americans-think-there-is-stigma-associated-with-mental-illness-cbs-news-poll [perma.cc/3AZZ-ZWS4].

58. *See* Philip T. Yanos et al., *The Impact of Illness Identity on Recovery From Severe Mental Illness: A Review of the Evidence*, PSYCHIATRY RSCH. (June 2020), www.pubmed.ncbi.nlm.nih.gov/32361335 [perma.cc/C92D-2PR5] (finding self-stigma has a negative impact on recovery for those with a severe mental illness).

59. *Stigma, Prejudice and Discrimination Against People with Mental Illness*, AM. PSYCHIATRIC ASSOC., www.psychiatry.org/patients-families/stigma-and-discrimination [perma.cc/TXM5-L3DT] (last visited Oct. 7, 2022).

60. *See Mental Health by the Numbers*, *supra* note 34; *see also* Philip S. Wang et al., *Delays in Initial Treatment Contact after First Onset of a Mental Disorder*, HEALTH SERV. RES. (Apr. 2004), www.ncbi.nlm.nih.gov/pmc/articles/PMC1361014 [perma.cc/89WU-HV4X] (noting the type of mental health professional contacted (i.e., general medical doctors, psychiatrists, mental health specialists, etc.) does not have a significant impact on the lapse of time between mental health symptoms and the treatment eventually received).

61. *See* Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, MILBANK Q. (Sept. 2010), www.ncbi.nlm.nih.gov/pmc/articles/PMC2950754 [perma.cc/J693-NY26] (reviewing the political history of mental health parity).

62. *See id.* ("The Blue Cross Blue Shield High Option Plan was the only plan remaining that provided parity-level psychiatric coverage, and so for a number of years, it attracted higher-cost beneficiaries until 1981 when it was permitted to cut its coverage significantly.").

63. *See id.* (noting that thirty-eight states passed minimum benefit levels for alcoholism, twenty-five states passed minimum benefit levels for drug abuse, and eighteen states passed minimum benefit levels for mental health treatment). These laws were limited and only set minimum levels, as opposed

early 1990s, there were two federal parity legislation attempts that failed.[64]

From that point forward, three federal statutes have largely shaped the landscape of MH/SUD parity: the Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008, and the Affordable Care Act.[65] Additionally, the 21st Century Cures Act and Consolidated Appropriations Act have positively influenced MH/SUD parity.[66] These laws are summarized in the following sections.

1. *Mental Health Parity Act ("MHPA")*

The MHPA was passed in 1996.[67] The MHPA prohibited large group health plans from applying more restrictive annual and lifetime dollar limits on mental health coverage than it does for med/surg coverage.[68] In most states, large group health plans are those with fifty-one or more employees.[69]

The MHPA was a first step towards mental health parity, but it was rather limited in scope.[70] The MHPA provided patients with

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to parity with med/surg benefits. *Id.*

64. *See id.* (noting failed parity legislation attempts). In 1992, Senators Pete Domenici (D-NM) and John Danforth (R-MO) introduced the first federal mental health parity legislation. *Id.* This bill would have required a minimum number of days of mental health coverage at a specified cost-sharing structure, along with full integration of mental health parity. *Id.* This bill was never passed. *Id.* In 1995, Senator Domenici and Senator Paul Wellstone (D-MN) introduced another parity bill that would have attached mental health parity with the Health Insurance Portability and Accountability Act ("HIPPA"). *Id.* The Senate voted sixty-eight to thirty to approve this bill as an amendment to HIPPA legislation, but it was later dropped during House-Senate conference negotiations. *Id.*

65. *See* Sarah Goodell, *Mental Health Parity*, HEALTH AFFAIRS (Apr. 3, 2014), www.healthaffairs.org/do/10.1377/hpb20140403.871424 [perma.cc/6KGW-4PQ9] (noting that, in addition to these federal statutes, President Bill Clinton ordered parity of MH/SUD treatment in the Federal Employees Health Benefits Program ("FEHB") beginning in 2001). This was the most expansive parity effort achieved at the time, covering cost sharing, deductibles, annual and lifetime limits, limits on the number of visits, and treatment limits. *Id.*

66. Don Sapatkin, *A Timeline of Parity Laws and Enforcement*, MIND SITE NEWS (Feb. 13, 2022), www.mindsitenews.org/2022/02/13/a-timeline-of-parity-laws-and-enforcement [perma.cc/XR85-YB2P] [hereinafter *A Timeline of Parity Laws*].

67. Goodell, *supra* note 65.

68. *Id.*

69. *See Large Group Health Plans*, ASSOC. HEALTH PLANS, www.associationhealthplans.com/glossary/small-group-health-plan [perma.cc/8ZBV-LNNG] (last visited Oct. 7, 2022) (noting that in four states—California, Colorado, New York, and Vermont—large group health plans are defined as more than 101 employees).

70. *See* Barry et al., *supra* note 61 (noting Senator Paul Wellstone, a major advocate of mental health parity and an individual who was instrumental in getting parity legislation passed, "expressed a mix of frustration and optimism

some financial protections stemming from unreasonably low annual and lifetime dollar limits for mental health coverage.[71] However, it stopped short of requiring parity for other benefit terms, such as the number of covered office visits and the allocation of cost sharing.[72] It also did not cover any SUD benefits.[73] Due to the narrow scope of the MHPA, it has been viewed as having a symbolic rather than a substantive impact on parity.[74]

2. *Mental Health Parity and Addiction Equity Act ("Federal Parity Law")*

The Federal Parity Law was passed in 2008.[75] The Federal Parity Law was passed in large part from the strong push of Representatives Patrick Kennedy (D-RI) and Jim Ramstad (R-MN), and Senators Paul Wellstone (D-MN) and Pete Domenici (R-NM).[76] These individuals dealt with mental health struggles, either personally or by caring for a family member..[77] They openly told their stories, humanizing the topic of MH/SUD, and guiding the Federal Parity Law through its final phases.[78] Former Rep. Patrick Kennedy has coined the battle for parity "a medical version of civil rights."[79]

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with the 1996 law, noting that 'we didn't even get half a loaf, we just got crumbs but it's a start.'").

71. *Id.*

72. *Id.*

73. *Id.*

74. Daniel Gitterman et al., *Toward Full Mental Health Parity and Beyond*, HEALTH AFFAIRS (July 2001), www.healthaffairs.org/doi/10.1377/hlthaff.20.4.68 [perma.cc/TR69-GP8C].

75. *Issue Brief: Parity*, MENTAL HEALTH AM., www.mhanational.org/issues/issue-brief-parity [perma.cc/XU8M-CD4X] (last visited Oct. 2, 2022).

76. Barry et al., *supra* note 61.

77. *See id.* (noting the Congressmen and Senators stories). Congressman Kennedy parked blocks away from his therapist's office so others would not find out he was receiving treatment for bipolar disorder. *Id.* After a late-night crash on Capitol Hill, Congressman Kennedy sought treatment at Mayo Clinic for his addiction to prescription medication, and publicly disclosed his struggles with mental health. *Id.* Congressman Ramstad "connected his commitment to parity to the day in 1981 when he woke up in a jail cell in South Dakota after an alcohol-induced blackout." *Id.* Senator Wellstone's brother, Stephen Wellstone, battled bipolar disorder and drug addiction. *Id.* When Stephen was a freshman in college, he suffered a severe mental breakdown and spent the next two years in mental hospitals. *Id.* Eventually, he recovered and graduated with honors, but it took his parents over twenty years to pay off the medical bills. *Id.* Senator Domenici was the father to eight children, and one of his daughter's demonstrated symptoms of schizophrenia in her late teens. *NAMI Mourns the Loss of Senator Pete Domenici*, NAMI (Sept. 13, 2017), www.nami.org/Press-Media/Press-Releases/2017/NAMI-Mourns-the-Loss-of-Senator-Pete-Domenici [perma.cc/X89D-S7BG]. When the Federal Parity Law was signed into law, Senator Domenici's daughter was receiving treatment for schizophrenia. *Id.*

78. Barry et al., *supra* note 61.

79. *A Family's Struggle to Care for Son's Autism*, *supra* note 55.

The goal of the Federal Parity Law is to "create parity by eliminating historical differences in group health insurance coverage" between MH/SUD and med/surg coverage.[80] The Federal Parity Law was intended to correct historical discriminatory issuer practices against those with MH/SUD conditions.[81] It built upon the MHPA and provided a meaningful expansion of parity for MH treatment.[82] Additionally, for the first time, the Federal Parity Law included SUD treatment.[83]

The following sections explain the applicability, criteria, and enforcement of the Federal Parity Law.

a. Applicability

The Federal Parity Law applies to group health plans.[84] A group health plan is an "employee welfare benefit plan that provides medical care to employees or their dependents."[85] Following the passing of the ACA, large group health plans, fully-insured small group health plans, and individual health plans are required to comply with the Federal Parity Law.[86] There is a cost exemption, allowing a plan issuer to be temporarily exempt from the Federal Parity Law if the total cost of the health plan increases by two percent in the first plan year that the law is applied, or one percent for subsequent plan years.[87] However, federal agencies have not yet disclosed if any plans have applied for and received this exemption.[88]

b. Criteria

Health insurance plans are evaluated for parity in six classification areas: (1) inpatient, in-network; (2) inpatient, out-of-

80. *See* Barry et al., *supra* note 61 (internal citations omitted).
81. *Issue Brief: Parity, supra* note 75.
82. *A Timeline of Parity Laws, supra* note 66.
83. *Id.*
84. 29 U.S.C. § 1185a (2013).
85. 42 U.S.C. § 300gg-91 (1944).
86. *Affordable Care Act: Coverage Terms*, SHRM, www.shrm.org/topics-tools/news/benefits-compensation/affordable-care-act-coverage-terms [perma.cc/ZXL3-SEN3] (last visited Dec. 2, 2022); *see also* Mike Roche, *An Employer's Guide to Fully Insured vs. Self Insured Health Plans*, THE ALLIANCE (Jan. 25, 2022), www.the-alliance.org/an-employers-guide-to-fully-insured-vs-self-insured-health-plans [perma.cc/D2SC-HVPC] (generally, a fully-insured plan is where the employer pays a set monthly premium for health insurance coverage and a self-insured plan is where the employer pays the actual employees' medical/prescription drug claims costs, subject to certain protections, like stop-loss coverage).
87. 29 U.S.C. § 1185a (2013).
88. Kaye Pestaina, *Mental Health Parity at a Crossroads*, KFF (Aug. 18, 2022), www.kff.org/report-section/mental-health-parity-at-a-crossroads-issue-brief [perma.cc/27NM-STLE].

network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.[89] To the extent a plan provides MH/SUD benefits falling under one or more of these categories, it must do so in a no less restrictive fashion than what is offered for med/surg coverage.[90]

Under the Federal Parity Law, a health plan may not apply more restrictive annual and lifetime dollar limits to MH/SUD coverage than it does for med/surg.[91] The financial requirements (e.g., co-payments, coinsurance, deductibles, out-of-pocket expenses) for MH/SUD may not be more restrictive than those imposed on med/surg benefits.[92] A plan cannot impose different cost-sharing structures for MH/SUD than it does for med/surg benefits.[93] When calculating the deductible, MH/SUD and med/surg benefits must be added together to meet a common deductible; a plan cannot impose a "separate but equal deductible."[94]

The treatment limitations (e.g., number of visits, number of days, frequency of treatment, or limits on the scope or duration of treatment) for MH/SUD may not be more restrictive than those imposed on med/surg benefits.[95] Treatment limitations are split into two groups, Quantitative Treatment Limitations ("QTL") and Non-Quantitative Treatment Limitations ("NQTL").[96] QTLs can be measured numerically, such as the number of inpatient days covered or number of outpatient visits permitted.[97] In contrast, NQTLs are any other limitation on coverage that is not numerical.[98] NQTLs include things like excluded services,[99] medical necessity,[100]

89. Ali Shana, *Mental Health Parity in the US: Have We Made Any Real Progress?*, PSYCHIATRIC TIMES (June 17, 2020), www.psychiatrictimes.com/view/mental-health-parity-in-the-us-have-we-made-any-real-progress [perma.cc/Z3YU-TJ3E].

90. *Issue Brief: Parity, supra* note 75.

91. Barry et al., *supra* note 61.

92. 29 U.S.C. § 1185a (2013).

93. *Issue Brief: Parity, supra* note 75.

94. *Id.*

95. 29 U.S.C. § 1185a (2013).

96. *Understanding Non-Quantitative Treatment Limitations (NQTLs)*, THE PHIA GRP., www.phiagroup.com/Media/Understanding-Non-Quantitative-Treatment-Limitations-NQTLs [perma.cc/2XQE-HWXY] (last visited Oct. 4, 2022).

97. *Mental Health Parity and Addiction Equity Act of 2008*, MICH. GOV'T DEPT. OF INS. AND FIN. SERV., www.michigan.gov/difs/consumers/insurance/%20health-insurance/mental-health-parity/mental-health [perma.cc/G9DN-EKFR] (last visited Oct 4. 2022).

98. Pestaina, *supra* note 88.

99. *See Excluded Services*, HEALTHCARE.GOV, www.healthcare.gov/glossary/excluded-services [perma.cc/8F7Z-FCD9] (last visited Feb. 15, 2023) (noting that excluded services are "[h]ealth care services that your health insurance or plan doesn't pay for or cover").

100. *See* discussion *infra* Sections III.B.3 (Variations in Medical Necessity Criteria) and IV.A.3 (The Federal Parity Law Should be Amended to Require Medical Necessity Determinations Consistent with Generally Accepted

network adequacy,[101] prior authorizations,[102] and step therapy protocols.[103]

Upon request, the criteria used for medical necessity determinations and the reasons for any denial must be provided to contracted providers, the plan participant, or the beneficiary.[104] These disclosures are intended to increase transparency of medical necessity determinations.[105]

c. Enforcement

The Federal Parity Law falls under the Employee Retirement Income Security Program Act ("ERISA").[106] The Department of Labor ("DOL"), Department of Health and Human Services ("HHS"), and Department of the Treasury ("Treasury"), are responsible for enforcing the Federal Parity Law.[107] Specifically, for private health plans, the Employee Benefits Security Administration ("EBSA"), an agency of the DOL, has broad oversight of Federal Parity Law compliance.[108] Additionally, the Centers for Medicare & Medicaid Services ("CMS") is tasked with carrying out HHS enforcement efforts, and has the authority to step in if a state fails to "substantially enforce" parity.[109] Additionally, the U.S. Government Accountability Office ("GAO") is responsible for analyzing specific trends, patterns, and rates in coverage and exclusion of specific MH/SUD diagnoses by issuers and plans.[110]

Standards of Care).

101. *See* discussion *infra* Section II.D.2 (Network Adequacy).

102. *See Preauthorization*, HEALTHCARE.GOV, www.healthcare.gov/glossary/preauthorization [perma.cc/V4L5-7YEX] (last visited Feb. 15, 2023) (stating that prior authorization requires a patient to seek approval from their insurer for treatment before they receive it, except in an emergency).

103. *See Step Therapy Frequently Asked Questions,* CIGNA (Aug. 2014), www.cigna.com/pdf/step-therapy-faqs.pdf [perma.cc/8PYQ-T5N5] (noting that step therapy is a "prior authorization program that encourages the use of less costly yet effective medications before more costly medications are approved for coverage").

104. 29 U.S.C. § 1185a (2013).

105. *Issue Brief: Parity, supra* note 75.

106. 29 U.S.C. § 1185a (2013). ERISA is a federal law covering certain private retirement and health plans. *Employee Retirement Income Security Act (ERISA)*, U.S. Dept. of Labor, www.dol.gov/general/topic/retirement/erisa [perma.cc/9U5G-V4RM].

107. *2022 Report to Congress*, *supra* note 53, at 11, 25.

108. *See id.* at 51 (estimating EBSA has primary enforcement jurisdiction of the Federal Parity Law for approximately two million group health plans covering roughly 137 million Americans).

109. *See id.* at 25 (noting in 2021, CMS was the direct enforcer of the Federal Parity Law in Missouri, Texas, and Wyoming). *Id.* Additionally, six states (Alabama, Florida, Louisiana, Montana, Oklahoma, and Wisconsin) have entered into collaborative enforcement agreements with CMS, allowing the state to refer the matter to CMS for possible enforcement action if it is unable to obtain compliance by an issuer. *Id.*

110. Barry et al., *supra* note 61.

The DOL is required to submit a biennial report to Congress on Federal Parity Law compliance and has done so since 2012.[111] Thus far, six reports to Congress have been issued.[112] In the most recent 2022 Report to Congress, a NQTL comparative analyses was also included, as required by the CAA.[113] Going forward, the NQTL comparative analyses will be reported annually, and the latest comparative analysis was released in July 2023.[114]

3. Affordable Care Act ("ACA")

The ACA was passed in 2010.[115] This Act broadened the reach of parity by requiring fully-insured small group and individual health plans that were originally exempt from the Federal Parity Law to comply.[116]

The ACA established a set of ten Essential Health Benefits ("EHB"), which includes behavioral health coverage.[117] This requires all fully-insured small group and individual health plans to cover: (1) behavioral treatment, such as counseling and psychotherapy; (2) mental and behavioral health inpatient services; and (3) SUD treatment.[118]

The ACA broadened the commercial insurance industry by redesigning the small group and individual health insurance

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111. *2022 Report to Congress*, *supra* note 53, at 3-4.

112. *See id.* (indicating MHPAEA Reports to Congress were issued in 2012, 2014, 2016, 2018, 2020, and 2022). The next report will be issued in 2024. *Id.*

113. *Id.*

114. *Id.; see also 2023 MHPAEA Comparative Analysis Report to Congress,* U.S. DEPT. OF LABOR, U.S. DEPT. OF HEALTH & HUM. SERV., AND U.S. DEPT. OF THE TREASURY (July 2023), www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis [perma.cc/5AMD-N9NX] [hereinafter *2023 Comparative Analysis Report to Congress*].

115. *Affordable Care Act: Coverage Terms*, *supra* note 86.

116. Kristen Beronio et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, ASPE (Feb. 19, 2013), www.aspe.hhs.gov/reports/affordable-care-act-expands-mental-health-substance-use-disorder-benefits-federal-parity-protections-0 [perma.cc/FN3Q-6UDZ].

117. *See Ten Essential Health Benefits Insurance Plans Must Cover Under the Affordable Care Act*, FAMILIESUSA (Feb. 9, 2018), www.familiesusa.org/resources/10-essential-health-benefits-insurance-plans-must-cover-under-the-affordable-care-act [perma.cc/4452-BDQ2] [hereinafter *Ten Essential Health Benefits*] (noting the ten categories of EHBs are: (1) ambulatory patient services (outpatient services); (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) MH/SUD services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitation and habilitation services and devices; (8) laboratory services; (9) preventative and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care).

118. *Mental Health & Substance Abuse Coverage*, HEALTHCARE.GOV, www.healthcare.gov/coverage/mental-health-substance-abuse-coverage [perma.cc/E2CN-5BYH] (last visited Nov. 18, 2022).

market, including establishing health insurance exchanges, the individual mandate, and low-income subsidies for premiums and cost sharing.[119] While not fully extinguishing the financial burden associated with purchasing health insurance, these initiatives have helped alleviate a portion of the cost.[120]

Those living with MH/SUD are disproportionately represented among the uninsured.[121] The ACA prohibits discrimination against individuals with pre-existing conditions, including MH/SUD conditions, allowing a greater number of individuals to obtain insurance coverage.[122] As of early 2023, more than forty million Americans were enrolled in health coverage related to the ACA.[123] Accordingly, a greater number of individuals have gained the promise of parity.[124] However, critical coverage gaps and enforcement issues in parity law remain.[125]

4. *Other Legislative Actions*

Since the ACA was passed in 2010, two other legislative developments have shaped the current state of parity law – the Cures Act and the CAA.[126]

a. 21st Century Cures Act ("Cures Act")

The Cures Act was signed into law in 2016.[127] The Cures Act focused on slowing the epidemic of opioid-related deaths.[128] It also

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119. *See id.* (noting that in addition, the ACA also expanded Medicaid coverage).

120. *What the Affordable Care Act Has Meant for People with Mental Health Conditions – and What Could Be Lost*, NAT'L ALL. ON MENTAL ILLNESS 2 (Nov. 10, 2020), www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/What-the-Affordable-Care-Act-Has-Meant-for-People-with-Mental-Health-Conditions-What-Could-Be-Lost/NAMI_IssueBrief_ACA_11-10-20 [perma.cc/UGN7-BNE9].

121. Richard G. Frank et al., *Behavioral Health Parity and the Affordable Care Act*, J. SOC. WORK DISABIL. REHAB. (Feb. 19, 2015), www.ncbi.nlm.nih.gov/pmc/articles/PMC4334111 [perma.cc/U865-P66R].

122. *Id.*

123. *Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates*, ASSISTANT SEC'Y FOR PLAN. AND EVALUATION (March 23, 2023), www.aspe.hhs.gov/sites/default/files/documents/8e81cf90c721dbbf58694c98e85804d3/health-coverage-under-aca.pdf [perma.cc/46RU-LCPZ].

124. Frank et al., *supra* note 121.

125. *Id.*

126. *A Timeline of Parity Laws, supra* note 66.

127. 21st Century Cures Act of 2016, Pub. L. No. 114-255.

128. *See A Timeline of Parity Laws, supra* note 66; *see also* Gregory Korte, *Obama Signs $6.3 Billion Law for Cancer Research, Drug Treatment*, USA TODAY (Dec. 13, 2016), www.usatoday.com/story/news/politics/2016/12/13/obama-signs-63-billion-law-cancer-research-drug-treadment/95382708/# [perma.cc/5DMS-NA3D] (discussing former President Barack Obama's

clarified that under the Federal Parity Law, treatment for eating disorders is considered an MH/SUD condition, not a med/surg condition.[129] Finally, it ordered federal agencies to distribute additional guidance on parity regulations and develop plans for improving enforcement, including parity enforcement in NQTLs.[130]

b. Consolidated Appropriations Act ("CAA")

In response, the CAA was passed in 2020.[131] The CAA amended the Federal Parity Law to step up the comparative analyses of NQTLs.[132] Section 203 of the CAA requires health plans to "perform and document comparative analyses of the design and application of NQTLs."[133] The NQTL comparative analyses involves five steps, including analyzing: (1) the NQTL terms and a description of all MH/SUD and med/surg benefits that each NQTL applies; (2) the factors used to determine the NQTL will apply; (3) the evidentiary standards used to develop the factors; (4) a comparative analysis demonstrating the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringent for MH/SUD than med/surg; and (5) the specific findings and conclusions reached for coverage determinations.[134] Upon request, these comparative analyses must be provided to the DOL, HHS, and Treasury.[135]

Under the CAA, the DOL, HHS, and Treasury must request the comparative analyses of NQTLs from at least twenty group health plans and/or health insurance issuers annually.[136] Following receipt, these agencies issue an annual report to Congress and publicly disclose the results, including the names of the group health plans, whether the plans submitted sufficient information, and if the plan is compliant with the Federal Parity Law.[137] Non-compliant issuers and plan sponsors are required to notify all enrolled individuals within seven days.[138] The 2022 Report to

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comments on the opioid epidemic, stating "[t]his is an epidemic that can touch anybody—blue-collar, white collar, college students, retirees, kids, moms, dads.").

129. Pestaina, *supra* note 88.

130. *A Timeline of Parity Laws, supra* note 66.

131. Consol. Appropriations Act of 2021, Pub. L. No. 116-260.

132. Ruth Anne Collins Michels & Kristine M. Bingman, *Consolidated Appropriations Act Underscores Mental Health Parity Compliance*, OGLETREE DEAKINS (Jan. 27, 2021), www.ogletree.com/insights/consolidated-appropriations-act-underscores-mental-health-parity-compliance [perma.cc/VN64-2C5A].

133. *Id.*

134. *2022 Report to Congress, supra* note 53, at 10.

135. Michels & Bingman, *supra* note 132.

136. *Id.*

137. *Id.*

138. *2023 Comparative Analysis Report to Congress*, *supra* note 114, at 58, 77.

Congress was the first report to include the NQTL comparative analyses, and a standalone comparative analyses report was published in July 2023.[139]

C. State Parity Laws

The Federal Parity Law is the floor for parity regulations.[140] States may, if they choose, provide more protective parity regulations than is required by the Federal Parity Law.[141] Every state and the District of Columbia has passed its own state parity laws.[142] State parity laws only apply to fully-insured health plans, as self-insured plans are regulated by ERISA.[143]

The state department of insurance is primarily responsible for enforcing parity at the state level.[144] Some state attorneys general have also brought forth actions for parity noncompliance, typically falling under their authority to oversee consumer protection laws.[145]

There is considerable variance between state parity laws, including in the type of health plan covered and the scope of requirements.[146] The discrepancy in state parity laws is mainly driven from issuer competition and based on the consumer-friendly nature of the individual state's insurance division.[147]

Additionally, there is no uniform ranking system of state parity initiatives.[148] For example, in one analysis, Maryland, Virginia, Massachusetts, Vermont, and Pennsylvania were found to have the highest ranking MH/SUD care based on cost, access, and quality.[149] In another, Wisconsin, Pennsylvania, Massachusetts, Delaware, and Connecticut were ranked most favorably based on the lowest

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139. *See infra* Section III.C.1 (Federal Enforcement Findings).

140. *See* Sarah Goodell, *Enforcing Mental Health Parity*, HEALTH AFFAIRS (Nov. 9, 2015), www.healthaffairs.org/do/10.1377/hpb20151109.624272 [perma.cc/GJ9F-59ML] [hereinafter *Enforcing Mental Health Parity*] (noting the Federal Parity law does not preempt more stringent state parity laws).

141. *See Issue Brief: Parity, supra* note 75.

142. *Mental Health Benefits: State Laws Mandating or Regulating*, NAT'L CONF. OF STATE LEGISLATURES (Dec. 30, 2015), www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx [perma.cc/Q8X2-3CYD].

143. *See 2021 Employer Health Benefits Survey*, KFF (Nov. 10, 2021), www.kff.org/report-section/ehbs-2021-section-10-plan-funding [perma.cc/3X98-CMGW] (stating ERISA exempts private employer self-insured plans from most insurance laws, including premium taxes, reserve requirements, mandated benefits, and many consumer protection regulations).

144. *State and Federal Oversight of Compliance with Parity Requirements Varies*, GAO 17 (Dec. 2019), www.gao.gov/assets/gao-20-150.pdf [perma.cc/DU82-8KEZ][hereinafter *2019 GAO Report*].

145. *Id.*

146. *Issue Brief: Parity, supra* note 75.

147. Shana, *supra* note 89.

148. *See, e.g.*, Reinert et al., *supra* note 39, at 9.

149. Stephanie Horan, *Best and Worst States for Mental Healthcare*, HEALTHCARE INSIDER (Jan. 27, 2022), www.healthcareinsider.com/best-states-for-mental-healthcare-346733 [perma.cc/9WBQ-RUSJ].

rate of mental illness and the highest rate of access to care.[150] Overall, a nonuniform ranking system makes comparison of parity regulations between the states onerous.[151]

D. Other Considerations in Parity Law

There are many factors that influence the effectiveness of federal and state parity laws.[152] Notable considerations include the availability and affordability of health insurance, and network adequacy.[153]

1. The Availability and Affordability of Health Insurance

A gap in the availability and affordability of health insurance compounds existing barriers to parity.[154] Parity protections only apply to those with health insurance.[155] In 2020, eleven percent of Americans (5.5 million) with a mental illness were uninsured.[156] Sixty-two percent of those who were uninsured were unable to receive treatment for depression and/or anxiety, in comparison to those with private insurance, where thirty-seven percent were unable to obtain treatment.[157]

In parallel, the number of Americans covered by Medicaid[158] has declined in recent years.[159] Medicaid is the single largest payer

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150. Reinert et al., *supra* note 39, at 9.

151. *See generally* JoAnn Volk et al., *States Struggle to Ensure Equal Access to Behavioral Health Services Amid Mental Health Crisis*, GEORGETOWN CTR. ON HEALTH INS. REFORMS (Oct. 13, 2022), www.rwjf.org/en/insights/our-research/2022/10/states-struggle-to-ensure-equal-access-to-behavioral-health-services-amid-mental-health-crisis.html [perma.cc/7WBG-PNA5].

152. Reinert et al., *supra* note 39, at 9.

153. *Id.*

154. *See generally* Stoddard Davenport et al., *How do Individuals with Behavioral Health Conditions Contribute to Physical and Total Healthcare Spending?*, MILLIMAN (Aug. 13, 2020), www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx [perma.cc/REE6-ATUU].

155. Nirmita Panchal et al., *How Does Use of Mental Health Care Vary by Demographics and Health Insurance Coverage*, HEALTH REFORM (Mar. 24, 2022), www.kff.org/health-reform/issue-brief/how-does-use-of-mental-health-care-vary-by-demographics-and-health-insurance-coverage [perma.cc/8E2W-69SM].

156. Reinert et al., *supra* note 39, at 23.

157. Panchal et al., *supra* note 155.

158. *See Policy Basics: Introduction to Medicaid*, CTR. ON BUDGET AND POL'Y PRIORITIES (Apr. 14, 2020), www.cbpp.org/research/health/introduction-to-medicaid [perma.cc/6SXP-36ZK] (defining Medicaid as "a public insurance program that provides health coverage to low-income families and individuals, including children, parents, pregnant women, seniors, and people with disabilities; it is funded jointly by the federal government and the states."). Each state operates its own Medicaid program within federal guidelines. *Id.*

159. *See* Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019*, U.S. CENSUS BUREAU (Sept. 15, 2020),

of MH/SUD coverage in the United States.[160] States that have expanded Medicaid coverage have seen favorable reductions in the number of uninsured adults with depression, and a reduction in those who delay MH treatment due to cost.[161]

The average total health care cost for those with a MH/SUD condition is $12,272 per year, which is nearly 3.5x the average total cost of those without a MH/SUD condition ($3,552 per year).[162] Those diagnosed with a MH/SUD condition have disproportionately faced economic disadvantages and report greater financial stress.[163] The financial stress of receiving MH/SUD treatment is escalated when care is denied, leaving families buried in debt.[164] Accordingly, the availability and affordability of health insurance is the first step to ensuring parity.[165]

2. *Network Adequacy*

Network adequacy is fundamental to the effectiveness of parity.[166] A recent statement from the American Hospital Association ("AHA") titled "America's Mental Health Crisis," noted that "our health care system is underfunded and understaffed to meet America's behavioral health needs."[167] For every one mental

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www.census.gov/library/publications/2020/demo/p60-271.html [perma.cc/PG4F-SK2D] (showing the percentage of Americans with Medicaid coverage decreased from twenty-one percent in 2018 to twenty percent in 2019).

160. Carrie E. Fry & Benjamin D. Sommers, *Effect of Medicaid Expansion on Health Insurance Coverage and Accessing Care Among Adults with Depression*, PSYCHIATRY SERV. (Nov. 1, 2018), www.pubmed.ncbi.nlm.nih.gov/30152271 [perma.cc/8ESQ-HTB2].

161. *See* Reinert et al., *supra* note 39, at 23 (showing the majority of states with the highest rates of uninsured adults living with a mental illness did not expand Medicaid by 2019-2020).

162. *See* Davenport et al., *supra* note 154 (analyzing 2017 medical and prescription drug claims data for twenty-one million commercially insured lives).

163. *See* Erica Coe et al., *How Affordable is Mental Healthcare? The Long-Term Impact on Financial Health*, MCKINSEY & CO. (Oct. 8, 2021), www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/how-affordable-is-mental-healthcare-the-long-term-impact-on-financial-health [perma.cc/FZ8S-XC2Y] (noting the bi-directional relationship between debt and mental illness).

164. *See, e.g.*, David P. v. United Healthcare Ins. Co., 564 F. Supp. 3d 1100, 1105 (D. Utah 2021) (denying care and forcing plaintiffs to pay over $177,000 out-of-pocket); Heather E. v. Cal. Physicians' Servs., No. 19-cv-415, 2020 U.S. Dist. LEXIS 136467, at *4 (D. Utah July 30, 2020) (denying care and leaving plaintiffs with $146,000 in unreimbursed expenses); Lyn M. v. Premera Blue Cross, 966 F.3d 1061, 1064 (10th Cir. 2020) (denying care costing over $80,000).

165. Panchal et al., *supra* note 155.

166. *See* 29 U.S.C. § 1185a (2013) (noting several NQTLs under the Federal Parity Law do evaluate aspects of network adequacy, including provider admission to a network, reimbursements rates, and restrictions on facility-type).

167. *America's Mental Health Crises*, *supra* note 52.

health provider, there are 350 individuals in need of service.[168] Over 122 million people live in a designated Mental Health Shortage Area.[169] A Mental Health Shortage Area is "a geographic area, population group, or health care facility that has been designated by the Health Resources and Services Administration ("HRSA") as having a shortage of health professionals."[170] One driver of the mental health shortage is low reimbursement rates for MH/SUD providers.[171] For example, for in-network office visits, MH/SUD providers are reimbursed twenty-four percent less than primary care providers.[172]

A sufficient network of MH/SUD providers is paramount to the promise of parity.[173] When there is an insufficient number of providers, consumers are forced to pay higher costs for out-of-network care, travel long distances, endure long wait times, or forego treatment altogether.[174] Phantom networks – insurance directories stacked with providers who are not actually delivering services – have become increasingly common, forcing those in need to contact many providers before receiving care.[175] Phantom networks have irreversible consequences, since "for some

168. *See* Reinert et al., *supra* note 39, at 29 (defining "mental health providers" as "psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care").

169. *See Health Workforce Shortage Areas*, HEALTH RES. & SERV. ADMIN., www.data.hrsa.gov/topics/health-workforce/shortage-areas [perma.cc/K5PZ-GKTA] (last visited Feb. 2, 2024) (comparatively, seventy-four million people live in a Primary Care Shortage Area and fifty-seven million people live in a Dental Health Shortage Area).

170. *See Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/P) Scoring Criteria*, HHS (Aug. 1, 2019) www.hhs.gov/guidance/document/hpsa-and-muap-hpsa-scoring-criteria [perma.cc/D764-YE2L] (determining Health Professional Shortage Areas based on three scoring criteria: (1) population to provider ratio; (2) percentage of the population below 100% of the Federal Poverty Level; and (3) travel time to the nearest source of care outside the HPSA designation). In addition, there are other scoring methodologies for each discipline, including mental health. *Id.*

171. Steve Malek et al., *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network use and Provider Reimbursement*, MILLIMAN RSCH. REP. 32 (Nov. 19, 2019), www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p [perma.cc/65PM-9DAV].

172. *See id.* (based on claims data from calendar year 2013 through 2017).

173. Ellen Weber, *Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services,* LEGAL ACTION CTR. 3 (May 2020), www.lac.org/assets/files/Network-Adeqaucy-Spotlight-final-UTO.pdf [perma.cc/5WM9-KGF6].

174. *Id.*

175. Katherine Ellison, *73 doctors and None Available: How Ghost Networks Hamper Mental Health Care*, THE WASH. POST (Feb. 19, 2022, 9:00 AM), www.washingtonpost.com/health/2022/02/19/mental-health-ghost-network [perma.cc/VJF3-Y354].

individuals who are barely holding on, one call is all they have."[176] Although parity law continues to develop, there remains gaps in its application and enforcement.

III. ANALYSIS

The evolution of parity law has established parity as a right.[177] However, enforcing the right to parity is inconsistent and complex.[178] Issuers struggle with the complicated and unclear regulatory process.[179] Providers are caught between the consumer and the issuer, and many resort to not accepting insurance at all.[180] And worse, the consumer is stuck in the middle, left to "fend for themselves," often in the midst of a MH/SUD crisis.[181]

This section will analyze the complexity of parity law. It will also evaluate the gaps in the Federal Parity Law and recent federal enforcement findings and actions. Finally, this section will analyze the gaps in state parity laws and recent state enforcement findings and actions.

A. The Complexity of Parity Law

The complexity of parity stems from the patchwork of state and

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176. *See id.* (citing Heidi Strunk, the Chief Executive of Mental Health America of California).

177. *What is Parity*, THE KENNEDY F., www.parityregistry.org/what-is-parity [perma.cc/EZ5D-8MRH] (last visited Sept. 18, 2022).

178. *Enforcing Mental Health Parity*, *supra* note 140.

179. *See* Liv Osby, *Despite Congressional Approval, Mental Health Parity Still Not a Reality*, GREENVILLE BUS. MAG. (May 11, 2022, 3:31 PM), www.greenvillebusinessmag.com/2022/05/11/400019/despite-congressional-approval-mental-health-parity-still-not-a-reality [perma.cc/YMJ9-ZQ44] (stating issuers have requested robust templates, tools with examples of complex benefits analyses, and de-identified examples of violations to assist with compliance); *see also* Kelsey Waddill, *Industry Reacts to Report on Payer Mental Health Parity Compliance*, HEALTH PAYER INTEL. (Feb. 1, 2022), www.healthpayerintelligence.com/news/industry-reacts-to-report-on-payer-mental-health-parity-compliance [perma.cc/HGZ4-EY9Y] (noting issuers have "underscored their support for mental healthcare" and have "reiterated their demands for more clarity around compliance protocols.").

180. *See* Megan Leonhardt, *What You Need to Know About the Cost and Accessibility of Mental Health Care in America*, CNBC (May 10, 2021, 3:30 PM), www.cnbc.com/2021/05/10/cost-and-accessibility-of-mental-health-care-in-america.html [perma.cc/ZK88-KHC2] (stating only fifty-six percent of psychiatrists accept commercial insurance in comparison to ninety percent of other, non-mental health physicians); *see also* Margie Ryerson, *I'm a Therapist. Here's Why I Don't Take Insurance.*, SLATE (Sept. 16, 2022, 8:00 AM), www.slate.com/technology/2022/09/therapist-insurance-copay-reimbursement-affordable.html [perma.cc/6EEL-MPQE] (stating mental health providers refuse to accept insurance because of the administrative burden of complying with issuer requirements, frustration with questioning on medical necessity, and stagnant reimbursement rates).

181. *See Enforcing Mental Health Parity*, *supra* note 140.

federal agencies responsible for enforcement.[182] The DOL can investigate Federal Parity Law violations but must refer cases to the Treasury for assessing civil penalties.[183] State insurance agencies are responsible for enforcing parity on a state level, but if a state agency fails to "substantially enforce" parity, CMS has the authority to step in and assess civil monetary penalties.[184]

Enforcing parity is even more difficult when there is no logical equivalent between MH/SUD conditions and med/surg conditions.[185] For example, particular treatment settings may be used for MH/SUD that are not relevant in med/surg, such as intensive outpatient programs or long-term rehab stays.[186] The fundamental differences in these MH/SUD treatment settings elicits illusory equivalents to med/surg and creates challenges when analyzing the equivalency of care.[187]

Finally, consumers are often unaware of their right to parity.[188] Despite well-intentioned efforts to promote and publicize the right to parity by agencies and advocacy groups, overall awareness is lacking.[189] A 2014 study showed that only four percent of Americans were aware of their right to parity.[190] For parity violations, the burden is largely placed on the consumer to file individual claims of discrimination.[191] Individuals in the midst of a MH/SUD crisis may

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182. *Mental Health Parity*, NAT'L ALL. ON MENTAL ILLNESS, www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Parity [perma.cc/66TR-DPU6] (last visited Oct. 2, 2022).

183. *See* Lenny Bernstein, *Equal Mental Health Insurance Coverage Elusive Despite Legal Guarantee*, THE WASH. POST (Jan. 2, 2022, 7:00 AM), www.washingtonpost.com/health/2022/05/25/equal-mental-health-insurance-coverage-elusive-despite-legal-guarantee [perma.cc/RMW5-BNAR] (noting that although the Treasury can impose a $100 per day per affected individual excise tax for parity violations, this has never been done). The DOL is reluctant to use this penalty because the excise tax would be imposed on employers, not the issuers and administrators who are typically responsible for parity violations. *Id.*; *see also 2019 GAO Report, supra* note 144, at 24 ("DOL officials noted that the excise tax goes to the Treasury rather than toward payment of claims for plan members, and the DOL's focus is on obtaining payment of claims.").

184. Pestaina, *supra* note 88.

185. *Id.*

186. *Enforcing Mental Health Parity*, *supra* note 140.

187. *Id.*

188. Pestaina, *supra* note 88.

189. *Only 4 Percent of Americans Know about Mental Health Parity*, AM. PSYCH. ASSOC. (July 2014), www.apa.org/monitor/2014/07-08/upfront-health-parity [perma.cc/J6WL-EWCE].

190. *Id.*

191. *Enforcing Mental Health Parity*, *supra* note 140. To plead a claim under the Federal Parity Law, a plaintiff must generally allege: "(1) the relevant group health plan is subject to the Parity Act; (2) the plan provides both medical/surgical benefits and mental health or substance use disorder benefits; (3) the plan includes a treatment limitation for mental health or substance use disorder benefits that is more restrictive than medical/surgical benefits; and (4) the mental health or substance use disorder benefit being limited is in the same classification as the medical/surgical benefit to which it is being compared."

be unaware or unable to submit a timely complaint.[192] Even when an individual is able to submit a complaint, the appeals process is burdensome.[193] Providers may fear retribution from issuers for filing complaints, creating a "chilling effect."[194] The lack of awareness to the right to parity makes complaints an unreliable indicator of parity noncompliance, as the prevalence of complaints is artificially low.[195] Due to these complexities, the enforcement of parity has proved extremely difficult.[196]

B. Gaps in the Federal Parity Law

Although the Federal Parity Law provided a meaningful step towards MH/SUD parity, crucial coverage gaps remain.[197] Accordingly, this section will analyze the gaps in the Federal Parity Law, including its limited reach, lack of definition for MH/SUD and med/surg conditions, and extreme variations in medical necessity criteria.

1. The Limited Reach of the Federal Parity Law

The Federal Parity Law has a limited reach of what it covers.[198] Unlike behavioral health benefits under the ACA, the Federal Parity Law does not require that a health plan offer MH/SUD coverage.[199] Rather, the Federal Parity Law only requires that if a health plan does offer MH/SUD treatment, that it do so in a no less restrictive manner than med/surg benefits.[200] As a practical matter, the majority of health plans include some sort of MH/SUD coverage, even if they are not required to do so.[201]

K.K. v. Premera Blue Cross, No. C21-1611-JCC, 2022 U.S. Dist. LEXIS 95710, at *5-6 (W.D. Wash. May 27, 2022); *see also* Julie L. v. Excellus Health Plan, Inc., 447 F. Supp. 3d 38, 54 (W.D.N.Y. 2020); Michael W. v. United Behav. Health, 420 F. Supp. 3d 1207, 1234 (D. Utah 2019) (stating variations of the test for Federal Parity Law violations).

192. Lindsey Vuolo, *Evaluating the Promise and Potential of the Parity Act on its Tenth Anniversary*, HEALTH AFFAIRS (Oct. 10, 2018), www.healthaffairs.org/do/10.1377/forefront.20181009.356245 [perma.cc/DG9X-LN7P].

193. *See* Schatt-Denslow, *supra* note 5 (After being denied in-patient care for suicidal ideations, Jake Machovsky's parents "received an overwhelming packet of papers in the mail and had no idea what to do and where to start.").

194. *See* Vuolo, *supra* note 192 (noting that in practice, few retribution actions have been identified, but the "fear likely creates a chilling effect").

195. *See 2019 GAO Report, supra* note 144, at 2 (reporting that although instances of parity noncompliance were identified, the extent of noncompliance is unknown due to the issues with complaints).

196. *Id.*

197. *Issue Brief: Parity, supra* note 75.

198. *Id.*

199. Pestaina, *supra* note 88.

200. *Issue Brief: Parity, supra* note 75.

201. *See Does Your Insurance Cover Mental Health Services?*, AM. PSYCH.

However, even when plans do cover MH/SUD conditions, the Federal Parity Law does not require the plan to cover specific conditions.[202] Instead, MH/SUD conditions are covered based on the specific terms of the health plan.[203] In response, many states have passed behavioral health coverage mandates that require issuers to cover certain behavioral health services.[204] However, these mandates are limited in scope and only apply to fully-insured plans.[205] Additionally, the competing definitions of MH/SUD and med/surg between plans makes the comparative review process especially complicated and resource intensive.[206]

2. *Defining MH/SUD Conditions*

Although the Federal Parity Law requires plans to compare MH/SUD and med/surg coverage, there is no standard definition for what conditions fall into each category, with the exception of eating disorders, which have been designated as a MH/SUD condition by the Cures Act.[207] Instead, the Federal Parity Law allows issuers to elect "generally recognized" independent standards of current medical practice to define MH/SUD and med/surg conditions.[208]

A standard is "generally recognized" when it is "generally accepted in the relevant medical community."[209] As examples of "generally recognized", the Federal Parity Law mentions the most current version of the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), the most current version of the International Classification of Diseases ("ICD"), or state guidelines.[210]

Depending on the standard a plan elects to use, the definitions for MH/SUD and med/surg may be broadened or narrowed.[211] For example, four behavioral health diagnoses differ significantly between DSM-5 and ICD-11: personality disorders, severe childhood irritability and anger, compulsive sexual behavior

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ASSOC. (Oct. 10, 2019), www.apa.org/topics/managed-care-insurance/parity-guide [perma.cc/5DVM-WEDG] ("Fortunately, the vast majority of large group plans already provided mental health benefits before the parity law took effect.").

202. Barry et al., *supra* note 61.

203. *Id.*

204. *See, e.g.*, 215 ILL. COMP. STAT. 5/370c (2021) (requiring health issuers to cover medically necessary treatment for MH/SUD beginning January 1, 2023); OR. REV. STAT. § 743A.168 (2018) (requiring treatment of chemical dependency, including alcoholism, and mental or nervous conditions); CAL. INS. CODE § 10144.51 (2016) (requiring health plans to cover behavioral health treatment for pervasive development disorder or autism).

205. Pestaina, *supra* note 88.

206. *Id.*

207. *Id.*

208. 19 C.F.R. § 2590 (2013).

209. 75 Fed. Reg. 5412 (2010).

210. 19 C.F.R. § 2590 (2013).

211. Pestaina, *supra* note 88.

disorder, and substance use disorders/substance dependence.[212]

The opportunity to choose between competing definitions leads to wide variations between plans and unequal protections for the consumer.[213] If a plan is able to define a condition as med/surg, it places the condition beyond the reach of parity regulations because parity is only focused on the equivalency of MH/SUD conditions.[214] The lack of a standardized definition for MH/SUD also makes the comparative review process difficult, since each plan may define MH/SUD and med/surg conditions differently.[215]

3. Variations in Medical Necessity Criteria

Medical necessity is considered a NQTL under the Federal Parity Law.[216] Accordingly, medical necessity criteria must be applied equally between MH/SUD and med/surg coverage.[217] Yet, MH/SUD claims are denied more than twice as often as general medical care.[218] These denials have adverse effects on those in need of treatment, leading to unemployment, disability, and even death.[219] Those in crisis are often told they are "not sick enough."[220]

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212. *See* Michael B. First et al., *An Organization-and Category-Level Comparison of Diagnostic Requirements for Mental Disorders in ICD-11 and DSM-5*, WORLD PSYCHIATRY (Feb. 2021), www.pubmed.ncbi.nlm.nih.gov/33432742 [perma.cc/FWJ3-MRPG] (comparing ICD-11 and DSM-5).

213. Pestaina, *supra* note 88.

214. *Id.*

215. *Id.*

216. 29 U.S.C. § 1185a (2013).

217. *Id.*

218. *See A Long Road Ahead*, NAT'L ALL. ON MENTAL ILLNESS (Apr. 2015), www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead [perma.cc/C86T-2JJ5] ("The reasonable expectation is that reported denials of care for mental health, substance use, and medical care would be roughly equal."). Note, the Final Rules of the Federal Parity Law make it clear that disparate outcomes alone are not determinative of parity non-compliance. 78 Fed. Reg. 68239 (2013).

219. *Mental Health Parity: Where Do We Stand as 2021 Comes to a Close?*, THE KENNEDY F. (Dec. 15, 2021), www.thekennedyforum.org/blog/mental-health-parity-where-do-we-stand-as-2021-comes-to-a-close [perma.cc/D96D-VEPT] [hereinafter *Where Do We Stand as 2021 Comes to a Close?*].

220. *See* Kari Eiring et al., *Exploring the Experience of Being Viewed as "Not Sick Enough": A Qualitative Study of Women Recovered from Anorexia Nervosa or Atypical Anorexia Nervosa,* J. EAT. DISORD. (2021), www.ncbi.nlm.nih.gov/pmc/articles/PMC8557476 [perma.cc/DTW8-WFMG] (noting the harmful effects of being told you are not "skinny enough" to have an eating disorder and the weight-based threshold to access treatment); *see also*, M. S. v. Premera Blue Cross, 553 F. Supp. 3d 1000, 1013 (D. Utah 2021) (finding plaintiff was not "so functionally impaired" to require RTC); N.R. v. Raytheon Co., 24 F.4th 740, 754 (1st Cir. 2022) (denying speech therapy for an autistic child because although he did not speak clearly, he had not lost his speech); Heather E. v. Cal. Physicians' Servs., No. 19-cv-415, 2020 U.S. Dist. LEXIS 136467, at *3 (D. Utah July 30, 2020) (denying sub-acute inpatient care because there was not a "significant impairment that cannot be managed" at a lower level of care).

Families are forced to go into financial ruin to help their loved one, taking out second mortgages on their homes, exhausting life savings, and plunging deeply into debt.[221]

Even if treatment is initially covered as medically necessary, it is often cut short at the insistence of issuers.[222] Behavioral health care currently operates as a crisis-driven response system, and patients often report care is denied as soon as they appear stable.[223] Treatment denied prematurely has catastrophic impacts on the individual, who is forced to forgo continued treatment or pay out-of-pocket.[224]

The Federal Parity Law fails to dictate standards for medical necessity.[225] Rather, it only requires that the criteria used to determine medical necessity be available for disclosure.[226] Accordingly, issuers are free to choose an established guideline or develop their own internal guidelines for determining medical necessity.[227] The ability to develop internal guidelines for medical necessity allows issuers to arbitrarily deny care, misaligned with generally accepted standards of care.[228]

Generally accepted standards of care are "agreed upon standards for treatment among clinicians that are reflected by non-profit clinical professional associations."[229] For example, the American Society of Addiction Medicine ("ASAM") is a nationally recognized professional association that provides criteria for addiction medicine.[230] When issuers are permitted to derive their own internal criteria for medical necessity, against the guidance of professional associations, it allows them to be more restrictive, erroneously denying needed care.[231]

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221. *Where Do We Stand as 2021 Comes to a Close?*, *supra* note 219.

222. *A Family's Struggle to Care for Son's Autism*, *supra* note 55.

223. Nicole Rapfogel, *The Behavioral Health Care Affordability Problem*, CTR. FOR AM. PROGRESS (May 26, 2022), www.americanprogress.org/article/the-behavioral-health-care-affordability-problem [perma.cc/BS9P-4WVE].

224. *See A Family's Struggle to Care for Son's Autism, supra* note 55 (noting patient's treatment for depression and suicidal ideations was cut short and the patient blamed himself, telling his therapist "I failed at treatment. There's no hope to keep living."); *see also* Cynthia Koons & John Tozzi, *As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage*, BLOOMBERG (May 16, 2019, 5:00 AM), www.bloomberg.com/news/features/2019-05-16/insurance-covers-mental-health-but-good-luck-using-it [perma.cc/RRF6-LLHP] (noting Max Tillitt lost his life to heroin overdose when he was twenty-one years old, just weeks after his treatment was cut short and he was discharged without a treatment plan).

225. 29 U.S.C. § 1185a (2013).

226. *Id.*

227. Pestaina, *supra* note 88.

228. *See, e.g.*, Wit v. United Behav. Health, Nos. 20-17363, 21-15193, 20-17364, 21-15194, 2022 U.S. App. LEXIS 7514, at *10-11 (9th Cir. Mar. 22, 2022).

229. *Where Do We Stand as 2021 Comes to a Close?, supra* note 219.

230. *Id.*

231. *We're One Step Closer to Making Mental Health and Addiction Care More Affordable*, THE KENNEDY F. (Oct. 5, 2022), www.thekennedyforum.org/

In response to the divergence in medical necessity criteria, more than fifteen states have enacted requirements to standardize medical necessity criteria.[232] For example, California, Illinois, and Oregon require issuers to use generally accepted standards of care for both MH and SUD determinations.[233] Similarly, at least eleven states require issuers to use ASAM criteria to determine medical necessity for SUD benefits.[234] Standardized criteria ensures consumers are shielded from arbitrary insurance denials that are out of step with generally accepted standards of care.[235]

In aggregate, the criteria used for medical necessity has largely been left to the issuer's discretion.[236] Due to a lack of federal oversight, the criteria used to determine medical necessity varies not only by state, but by individual plan within a single state.[237] State laws do not apply to self-insured plans, so even if a state requires generally accepted standards of care to be used, self-insured plans are not required to do the same.[238] Accordingly, there are varying medical necessity criteria across states and health plans, which is difficult to evaluate and enforce.[239]

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blog/were-one-step-closer-to-making-mental-health-and-addiction-care-more-affordable [perma.cc/C6T7-59J2].

232. *See Spotlight on Medical Necessity Criteria for Substance Use Disorders*, LEGAL ACTION CTR. 3 (Dec. 2020), www.lac.org/resource/spotlight-on-medical-necessity-criteria-for-substance-use-disorders [perma.cc/JWC3-GXJJ] (noting California, Colorado, Connecticut, Delaware, Illinois, Maryland, New Hampshire, New Jersey, New York, North Carolina, Rhode Island, Tennessee, Texas, Washington, and West Virginia require state-regulated commercial health plans to use specific criteria or level of care assessment tools to determine medical necessity for SUD treatment).

233. *See Where Do We Stand as 2021 Comes to a Close?, supra* note 219 (stating that following the enactment of S.B. 855, UnitedHealth Care is using ASAM Criteria for plans in California, and Aetna voluntary switched to using ASAM criteria nationwide).

234. *See Spotlight on Medical Necessity Criteria for Substance Use Disorders*, *supra* note 232, at 7 (noting Colorado, Connecticut, Delaware, Illinois, Maryland, New Hampshire, New Jersey, North Carolina, Rhode Island, Tennessee, and Washington use ASAM criteria to define medical necessity for SUD benefits).

235. *See generally Where Do We Stand as 2021 Comes to a Close?, supra* note 219 (encouraging insurers to make coverage decisions aligned with generally accepted standards of care) .

236. *Id.*

237. Pestaina, *supra* note 88.

238. *Id.*

239. *See generally* Jocelyn Guyer et al., *Speaking the Same Language: A Toolkit for Strengthening Patient-Centered Addiction Care in the United States*, AM. SOC'Y OF ADDICTION MEDICINE 9 (Nov. 9, 2021), www.asam.org/asam-criteria/toolkit [perma.cc/Y572-RF49] (noting the use of a well-defined approach to identify the level of patient care needed is one strategy states may use to improve addiction care).

C. Federal Enforcement

Although the Federal Parity Law was passed in 2008, enforcement has proved challenging.[240] Indeed, as Angela Kimball, the national director of advocacy and public policy for the National Alliance on Mental Illness ("NAMI") notes, there remains "a lack of oversight and efforts to make sure that health plans are compliant with not only the letter of the law, but the spirit of law."[241]

The 2022 Report to Congress and 2023 Comparative Analysis Report to Congress shed light on the current state of federal parity compliance.[242] Additionally, recent judicial enforcement actions and settlements demonstrate increased interest in holding issuers accountable.[243]

1. Federal Enforcement Findings

The Federal Parity Law was not "given teeth" until Congress passed the CAA in 2021.[244] Under the CAA, the DOL, HHS, and Treasury are required to provide an annual comparative report to Congress evaluating NQTLs, in addition to the biennial compliance report.[245] The most recent biennial compliance report was released in January 2022, and the most recent comparative report was released in July 2023.[246]

a. 2022 Report to Congress

The 2022 Report to Congress, which included a NQTL comparative analyses, was released in January 2022, and showed incredibly low levels of compliance with parity.[247] Of the 156 letters EBSA issued, and the fifteen letters CMS issued, none of the initial NQTL comparative analyses responses contained sufficient information to evaluate parity.[248] Additionally, about one-third resulted in initial determinations of noncompliance.[249] For each

240. Shana, *supra* note 89.

241. *Id.*

242. *2022 Report to Congress, supra* note 53; *2023 Comparative Analysis Report to Congress*, *supra* note 114.

243. *Id.*

244. Stephen Miller, *Mental Health Parity—Now, the DOL Really Means It*, SHRM (Mar. 31, 2022), www.shrm.org/topics-tools/news/benefits-compensation/mental-health-parity-now-dol-really-means [perma.cc/Q36A-6KAU].

245. Michels & Bingman, *supra* note 132.

246. *2022 Report to Congress*, *supra* note 53; *2023 Comparative Analysis Report to Congress*, *supra* note 114.

247. *2022 Report to Congress, supra* note 53, at 12-13.

248. *Id.*

249. Ali Khawar, *Mental Health Parity is the Law, and We're Enforcing it*, DEPT. OF LABOR (Jan. 25, 2022), www.blog.dol.gov/2022/01/25/mental-health-parity-is-the-law-and-were-enforcing-it [perma.cc/7PAR-AX4J].

instance of noncompliance, there are individuals who may have been erroneously denied necessary MH/SUD treatment.[250]

In response, many of the plans and issuers stated they were unprepared to respond to NQTL analyses requests, despite the CAA requiring plans to document and perform NQTL analyses by February 2021.[251] Some of the plans completed NQTL analyses for the first time only after the information was requested.[252] Others provided limited data on the factors and evidentiary standards used for specific NQTLs, which are essential elements in the multi-step NQTL review process.[253]

The 2022 report showed especially "egregious violations" of parity law in several areas, including: (1) "hundreds of self-funded plans across the country explicitly excluded evidence-based treatment for individuals with autism spectrum disorder;" (2) "plans excluded coverage for evidence-based medications for opioid-use disorder and required prior authorization for all out-patient mental health and SUD services;" and (3) "more than 1.2 million enrollees were denied benefits for nutritional counseling for mental health conditions such as anorexia nervosa, bulimia nervosa, and binge-eating disorder."[254]

Two facts are clear from the 2022 report: "insurers will not change their behaviors without increased enforcement and accountability, and patients will continue to suffer until that happens."[255]

In contrast, QTLs, which are also covered under the Federal Parity Law, are more straightforward and simpler to assess because they can be evaluated facially for discriminatory practices by reviewing issuer documentation.[256] Accordingly, following the enactment of the Federal Parity Law, non-compliance with QTLs is virtually extinct.[257]

NQTL analyses are more challenging than QTL analyses because NQTLs cannot be evaluated numerically.[258] For example, it

250. *Id.*

251. *2022 Report to Congress*, *supra* note 53, at 4.

252. *Id.*

253. 29 U.S.C. § 1185a (2013).

254. Letter from James L. Madara, CEO and Executive Vice President of AMA, to the House Comm. on Ways & Means (Feb 2, 2022) (on file with U.S. House of Representatives), available at www.ama-assn.org/delivering-care/patient-support-advocacy/insurer-accountability-mental-health-parity-long-overdue [perma.cc/3T7Y-H8HW].

255. *Id.*

256. *See generally* Amber Gayle Thalmayer et al., *The Mental Health Parity and Addiction Equity Act (MHPAEA) Evaluation Study: Impact on Quantitative Treatment Limits*, PSYCH. SERV. (Dec. 15, 2016), www.pubmed.ncbi.nlm.nih.gov/27974003 [perma.cc/JDK3-U2DN].

257. *See id.* ("Post-parity, QTLs almost entirely disappeared.").

258. Kelsey Waddill, *Top Reasons Why Health Plans Fail Mental Health Parity Compliance*, HEALTH PAYER INTEL. (Jan. 26, 2022), www.healthpayerintelligence.com/news/top-reasons-why-health-plans-fail-

is much easier to assess whether the number of covered outpatient treatment days, a common QTL, is disparately applied to MH/SUD, than it is to evaluate whether the requirements for prior authorization, a NQTL, are disparately applied as written and in operation.[259] The DOL has released support documentation to assist with NQTL analyses, including FAQs and a self-compliance tool, but issuers and regulators continue to wrestle with the difficulties and vagueness of the NQTL comparative process.[260]

b. 2023 Comparative Analysis Report to Congress

The 2023 Comparative Analysis Report to Congress was released in June 2023, focused on NQTLs.[261] Similar to the 2022 Report to Congress, none of the initial comparative analyses submitted were sufficiently detailed to demonstrate parity compliance.[262] Similarly, many plans and issuers remained unprepared to submit a comparative analyses upon request.[263] In total, EBSA issued three final determination letters of non-compliance, and CMS issued five final determination letters of non-compliance.[264]

The 2023 Comparative Analysis Report to Congress did provide a glimmer of hope – thirty-two plans and issuers provided corrective action plans to change their practices and/or remove NQTLs, and 104 plans and issuers agreed to make prospective changes to their plan designs.[265] In particular, the prospective changes are expected to impact more than four million consumers across over thirty-nine thousand plans by increasing access to MH/SUD benefits.[266] Notwithstanding, federal parity compliance remains low.[267]

2. Federal Enforcement Actions

Enforcement of the Federal Parity Law continues to receive judicial attention.[268] The Kennedy Forum estimates that in 2021, there were forty published court opinions related to the Federal

mental-health-parity-compliance [perma.cc/3DSR-3WF4].

259. *Id.*

260. *Id.*

261. *2023 Comparative Analysis Report to Congress*, *supra* note 114, at 1.

262. *Id.* at 50.

263. *Id.* at 51.

264. *Id.* at 8.

265. *Id.* at 57.

266. *Id.*

267. *See generally id.*

268. *See generally 2021 Parity Litigation Overview*, PARITYTRACK, www.paritytrack.org/legal-cases/2021-highlights [perma.cc/8WBF-H6TD] (last visited Oct. 2, 2022) (providing an overview of parity cases in 2021).

Parity Law.[269] These cases were adjudicated in district courts across eleven states.[270] Forty-five percent of cases adjudicated involved full or partially favorable rulings.[271] These figures are slightly down from 2020, where there were sixty published court opinions identified, with sixty-six percent resulting in full or partially favorable results.[272]

Two recent court cases dealing with the Federal Parity Law bear mentioning.[273] The first is *M.S. v. Premera Blue Cross*.[274] In *Premera Blue Cross*, Premera was ordered to pay $123,100 in statutory penalties, plus reasonable attorneys' fees, for plan disclosure violations of ERISA and the Federal Parity Law.[275] *Premera Blue Cross* involved the plaintiffs' minor son, who was diagnosed with autism spectrum disorder, anxiety, oppositional defiant disorder, and pervasive development disorder.[276] Following increasingly violent behavior and suicide threats, the plaintiffs sought continued treatment for their son in a residential treatment center ("RTC").[277] Premera denied RTC care stating it was not medically necessary.[278] The family appealed the issuer's decision, lost, and sued in federal court.[279] The court dismissed the ERISA recovery of benefits claim but ordered Premera to pay statutory penalties, stemming from Premera's three-year delay in turning over key documents to plaintiffs, such as the Administrative Services Agreement and medical necessity evaluation criteria.[280] *Premera Blue Cross* is the first instance of "a judge leveraging ERISA's statutory fines for a failure to disclose key documents related to parity legal action."[281]

The second important case recently decided is the landmark

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269. *Id.*

270. *See id.* (noting federal district court decisions involving the Federal Parity Law were adjudicated in California, Illinois, Indiana, Minnesota, Missouri, New Jersey, South Carolina, Tennessee, Utah, Washington, and Wisconsin). Half of the cases took place in Utah, "in large part due to the number of residential treatment centers (RTC) and outdoor behavioral health programs." *Id.*

271. *Id.*

272. *2020 Parity Litigation Overview*, PARITYTRACK, www.paritytrack.org/legal-cases/highlights [perma.cc/7C48-QFEC] (last visited Oct. 26, 2022).

273. *Legal Cases*, PARITYTRACK, www.paritytrack.org/legal-cases [perma.cc/AN36-99SU] (last visited Oct. 2, 2022).

274. M. S. v. Premera Blue Cross, 553 F. Supp. 3d 1000, 1041 (D. Utah 2021).

275. *Id.*

276. *Id.*

277. *See id.* (noting plaintiffs' son's behavior was so severe that it required local police assistance and a "Safety Intervention Plan" developed by son's therapist to keep the family safe).

278. *See id.* (noting Premera used InterQual Criteria to determine medical necessity).

279. *Id.*

280. *Id.*

281. *Legal Cases*, *supra* note 273.

decision of *Wit v. United Behavioral Health*.[282] *Wit* gained national attention after the United States District Court of Northern California found United Behavioral Health's ("UBH") internal medical necessity criteria was more restrictive than generally accepted standards of care.[283] The district court instructed UBH to reprocess more than sixty-seven thousand coverage claims for fifty thousand patients.[284] The district court decision was short lived, however, after the Ninth Circuit Court of Appeals reversed.[285] The Ninth Circuit found UBH's interpretation that plans do not have to be consistent with generally accepted standards of care for medical necessity was "not unreasonable."[286] In total, it is estimated that the *Wit* reversal threatens more than 130 million Americans right to MH/SUD coverage.[287]

The Ninth Circuit then issued a corrected ruling in January 2023 that was later vacated in August 2023.[288] The Ninth Circuit's August 2023 decision reconsiders the district court's findings, grants a panel rehearing, and remands the issue of the plan's administrative exhaustion requirement to the district court.[289] The August 2023 ruling has been seen as a step forward from the Ninth Circuit's previous decisions, "potentially opening the door for some plaintiff claims to be repossessed."[290]

Issuers also continue to settle claims of parity violations.[291] Notably, in August 2021, UBH was ordered to pay over $18 million dollars to settle a class action lawsuit after unlawfully denying over twenty thousand New Yorkers MH/SUD coverage.[292] This landmark settlement is the first joint state-federal enforcement action for

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282. Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2020 U.S. Dist. LEXIS 205435 (N.D. Cal. Nov. 3, 2020).

283. *Id.*

284. *See id.; see also Wit v. United Behavioral Health*, THE KENNEDY F., www.thekennedyforum.org/wit [perma.cc/J7G2-7JCK] (last visited Feb. 3, 2024) (noting the District Court released a comprehensive and robust decision finding for *Wit* that spanned more than 100 pages).

285. Wit v. United Behav. Health, Nos. 20-17363, 21-15193, 20-17364, 21-15194, 2022 U.S. App. LEXIS 7514 (9th Cir. Mar. 22, 2022), at *10-11 (reversing in a seven-page ruling).

286. *Id.*

287. Ryan Hampton, *Court decision endangers addiction and mental health coverage for 130 million Americans*, THE HILL (June 12, 2022, 12:30 PM), www.thehill.com/opinion/congress-blog/3520934-court-decision-endangers-addiction-and-mental-health-coverage-for-130-million-americans [perma.cc/8EPF-UK6Z].

288. Wit v. United Behav. Health, 58 F.4th 1080 (9th Cir. 2023), *vacated*; Wit v. United Behavioral Health, 79 F.4th 1068 (9th Cir. 2023).

289. *Wit*, 79 F.4th 1068, 1088-90.

290. *Wit v. United Behavioral Health*, *supra* note 284.

291. *See, e.g.*, Walsh v. United Behav. Health, E.D.N.Y., No. 1:21-cv-04519 (Aug. 11, 2021), available at www.ag.ny.gov/sites/default/files/nyag_united_settlements.pdf [perma.cc/LS6X-NC94].

292. *See id.* (noting the joint settlement by the DOL and New York Attorney General).

MH/SUD parity.[293] It also highlights the upwards trend of parity-related litigation and government enforcement actions.[294]

D. Gaps in State Parity Laws

Every state and the District of Columbia has adopted its own state parity laws.[295] These state laws apply to fully-insured employer plans and individual market policies; they do not apply to self-insured employer plans, which are regulated by ERISA.[296] In 2023, sixty-five percent of employees were enrolled in self-insured employer-sponsored health plans, leaving a large coverage gap of individuals unprotected by state regulations.[297] Generally, large employers may choose to self-insure to avoid state regulations, to evade some health insurance premium taxes, to maintain control over plan reserves, and to gain increased flexibility in their plan designs.[298]

State parity laws vary widely in scope from state-to-state.[299] Four states (Delaware, Illinois, New York, and Tennessee) have passed comprehensive parity legislation developed by the American Psychiatric Association, which includes issuer reporting requirements, commissioner implementation requirements, and coverage for medication-assisted treatment for SUD.[300] Twenty-three states have adopted mandatory parity compliance reporting.[301] But, other states have done very little to extend parity beyond federal requirements, forcing some individuals to move across the country in hopes of obtaining more protective state parity coverage.[302]

293. *A Breakdown of UnitedHealthcare's Recent Parity Settlements*, THE KENNEDY F. (Aug. 24, 2021), www.thekennedyforum.org/blog/a-breakdown-of-unitedhealthcares-recent-parity-settlements [perma.cc/Q2HM-V9RW].

294. *Id.*

295. *Mental Health Benefits: State Laws Mandating or Regulating*, *supra* note 142.

296. Pestaina, *supra* note 88.

297. *2023 Employer Health Benefits Survey*, KFF (Oct. 18, 2023), www.kff.org/report-section/ehbs-2023-section-10-plan-funding [perma.cc/U5WS-KWLS].

298. Gloria Sachdev et al., *Self-Insured Employers Are Using Price Transparency to Improve Contracting with Health Care Providers: The Indiana Experience*, HEALTH AFFAIRS (Oct. 7, 2019), www.healthaffairs.org/do/10.1377/forefront.20191003.778513/full [perma.cc/YQW5-AJG].

299. *Mental Health and Substance Use Disorder Insurance Coverage and Model Legislation*, AM. PSYCHIATRIC ASSOC., www.psychiatry.org/psychiatrists/advocacy/state-affairs/model-parity-legislation [perma.cc/P6V6-DUWE] (last visited Nov. 19, 2022) [hereinafter *Insurance Coverage and Model Legislation*].

300. *Id.*

301. *Where Do We Stand as 2021 Comes to a Close?, supra* note 219.

302. *See A Family's Struggle to Care for Son's Autism, supra* note 55 (noting that in one instance, a family moved from Virginia to California after their issuer denied Applied Behavioral Analysis ("ABA") as initially "not covered" and then "not necessary"). Desperate to help their young son, the family decided to

E. State Parity Enforcement

Parity enforcement varies by state, with some states regularly bringing actions to challenge parity and others bringing none.[303] This section will review recent state enforcement findings and actions.

1. State Parity Enforcement Findings

In 2019, the GAO released a report on parity enforcement.[304] The 2019 GAO report showed that nearly all states complete some type of pre-market form review of fully-insured group and individual health plans prior to the plan being approved for sale to consumers.[305] However, the scope of these form reviews vary by state.[306] While the majority of states review financial requirements and QTLs before the plan is approved, states vary in their review of NQTLs.[307] Additionally, these form reviews are constrained by tight, legislatively mandated deadlines.[308]

The 2019 GAO report also showed that only twenty-seven states reviewed parity compliance once the plan was active.[309] The scope and frequency of these reviews vary by state.[310] Some states conduct targeted reviews focused on specific issuers or compliance concerns, often driven by complaints received.[311] Other states review parity compliance during market conduct exams, which are utilized by nearly all states to confirm issuers are following

front the $25,000 bill for therapy. *Id.* The issuer eventually relented and approved treatment but continued to reject nearly all claims. *Id.* With compounding financial stress and the pending fear of bankruptcy, the family moved from Virginia to California, a state with historically more protective consumer parity laws. *Id.*

303. *State Parity Implementation Survey*, PARITYTRACK, www.paritytrack.org/reports [perma.cc/27D5-UH9Q] (last visited Nov. 10, 2022).

304. *2019 GAO Report, supra* note 144, at 17-20.

305. Rapfogel, *supra* note 223.

306. *2019 GAO Report, supra* note 144, at 17-20.

307. *See id.* (showing forty-two states reviewed issuers' documentation for at least one type of NQTL before consumers were permitted to enroll, but the extent of review varies).

308. JoAnn Volk et al., *A Review of State Efforts to Enforce Mental Health Parity: Lessons for Policymakers and Regulators*, MASSACHUSETTS ASS'N FOR MENTAL HEALTH 3 (Oct. 2022), www.mamh.org/library/a-review-of-state-efforts-to-enforce-mental-health-parity-lessons-for-policymakers-and-regulators [perma.cc/L2FL-EWLF] [hereinafter *A Review of State Efforts to Enforce Mental Health Parity*].

309. Rapfogel, *supra* note 223.

310. *Id.*

311. *2019 GAO Report, supra* note 144, at 17-20 (noting twelve states conducted at least one targeted review in 2017 and 2018).

applicable laws and regulations.[312] Some states conduct market conduct exams routinely (every three to five years), while other states complete market conduct exams on an as-needed basis.[313] Additionally, some states include parity compliance in market conduct exams, while others do not.[314] Regulators have noted that market conduct exams are a "really heavy lift" requiring significant time, money, and resources.[315]

In response, the National Association of Insurance Commissioners ("NAIC") released guidance for parity compliance in its Market Regulation Handbook, which the majority of states use to inform their market conduct exams.[316] Health issuers in most states are required to report market conduct data to NAIC annually using the market conduct annual statement ("MCAS") template.[317] The MCAS template includes three data requests related to parity – (1) prior authorizations requested, (2) prior authorizations approved, and (3) prior authorizations denied for MH/SUD benefits.[318] The data reported in the MCAS template helps state regulators identify potential outliers, such as issuers who disproportionately deny MH/SUD claims.[319]

State parity enforcement requires comparative analyses, which is both time- and resource-intensive.[320] Obtaining the data needed from issuers can be challenging, with regulators reporting that issuers sometimes provide a "data dump, submitting voluminous paperwork, lengthy claims manuals, or fluff."[321] Federal funding and guidance have alleviated a portion of the burden of enforcing parity, but regulators have voiced that additional funding and resources are needed.[322]

2. *State Parity Enforcement Actions*

Some states regularly enforce parity while others have yet to

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312. *Id.*

313. *See id.* (finding eighteen states routinely conduct market conduct exams, while twenty-nine states conduct market conduct exams on an as-needed basis).

314. *See id.* (finding nine states usually or always include a review of MH/SUD parity in market conduct exams).

315. *A Review of State Efforts to Enforce Mental Health Parity*, *supra* note 308, at 3.

316. *See Market Regulation Handbook*, NAT'L ASS'N OF INS. COMMISSIONERS (2022), www.content.naic.org/sites/default/files/publication-mes-hb-market-handbook-examination.pdf [perma.cc/73GR-LHAV] (providing the most recent version of the Market Regulation Handbook).

317. *A Review of State Efforts to Enforce Mental Health Parity*, *supra* note 308, at 10.

318. *Id.*

319. *Id.*

320. *Id.* at 3.

321. *Id.* (internal citations omitted).

322. *Id.*

bring any parity actions.[323] Since 2017, ten states have enforced parity violations against health plans and behavioral health organizations ("BHO").[324] These states include California, Connecticut, Delaware, Illinois, Massachusetts, New Hampshire, New York, Oregon, Pennsylvania, and Rhode Island.[325] While there is no single reason for these states to bring actions, studies have found that support for parity among state legislators is generally higher among "females, more liberal legislators, legislators in the Northeast region of the country, and those who had previously sought treatment for mental illness."[326]

Parity violations have been found in these states for a variety of reasons, including lack of timely access to services, unfavorable provider reimbursement rates, missing comparative analyses, and improper NQTL restrictions (e.g., excluded services, medical necessity, prior authorizations, and step therapy protocols).[327] Most recently, Kaiser Permanente agreed to a $200 million settlement for "deficiencies in the plan's delivery and oversight of behavioral healthcare," including timely access to care, and referral and network adequacy, among other things.[328]

Additionally, several states have identified parity violations through market conduct exams.[329] Recently, Pennsylvania imposed penalties on three large issuers after uncovering parity violations during a market conduct exam – including a $190 million penalty against Aetna, one-million dollar penalty against UnitedHealthcare, and $250 million penalty against UPMC.[330] In

323. *See* Shana, *supra* note 89 ("Maryland's attorney general just came out with 6 or 7 settlement agreements against a number of different insurers operating in that state for violations of parity.").

324. *Parity Enforcement Actions*, PARITYTRACK, www.paritytrack.org/resources/state-parity-enforcement-actions [perma.cc/VF9Z-NWUJ] (last visited Sept. 10, 2022).

325. *Id.*

326. Meagan Pilar, *An Examination of Factors Affecting State Legislators' Support for Parity Laws for Different Mental Illnesses*, CMTY. MENTAL HEALTH J. (Jun. 11, 2022), www.ncbi.nlm.nih.gov/pmc/articles/PMC9188272 [perma.cc/6DR9-EZ9K].

327. *Parity Enforcement Actions*, *supra* note 324.

328. Dave Muoio, *Kaiser Permanente Agrees to $200M Settlement After Investigation Reveals 'Several' Behavioral Care Deficiencies*, FIERCE HEALTHCARE (Oct. 17, 2023), www.fiercehealthcare.com/regulatory/kaiser-permanente-agrees-200m-settlement-after-investigation-reveals-several-behavioral [perma.cc/94NB-9PR5] (noting the 2023 Kaiser settlement includes $150 million towards strengthening behavioral health delivery over the next five-years).

329. *2019 GAO Report*, *supra* note 144, at 17.

330. *See* Mark Moran, *Aetna Sued in Pa. for Parity Lapses in Autism, Substance Use Disorder Coverage*, PSYCHIATRIC NEWS (Feb. 26, 2019), www.psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2019.3a13 [perma.cc/W59N-MTUP] (noting Pennsylvania penalized Aetna $190,000 after discovering violations for autism coverage and confusing policy language for certain SUD services). Aetna also agreed to pay over $20,000 in restitution to

all cases, regulators report the issuers were cooperative.[331] Still, forty states and the District of Columbia have yet to publish any enforcement actions, demonstrating the wide variance in state actions.[332]

IV. PROPOSAL

The difficulty of parity enforcement begins with the fact that issuers operate in a competitive, for-profit environment.[333] In 2021, the top issuers brought in billions in profit, led by UnitedHealth Group, reporting $17.3 billion in earnings.[334] The top five health issuers represent almost half of the total U.S. market share in the health insurance industry.[335] The competitiveness of the insurance industry necessitates that parity be enforced in a uniform, consistent manner. Otherwise, issuers may continue to feel pressured to deny coverage because "every other plan does it" and

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consumers for wrongly denied claims and interest on delayed payments. *Id.*; *see also* Christopher Snowbeck, *UnitedHealthcare Assessed $1 Million Penalty For Claims Payment Violations*, STAR TRIBUNE (Nov. 4, 2019, 7:27 PM), www.startribune.com/unitedhealthcare-assessed-1-million-penalty-for-claims-payment-violations/564370152 [perma.cc/5ESZ-MT2A] (noting Pennsylvania penalized UnitedHealthcare one-million dollars for violating the Federal Parity Law and other state regulatory requirements). United agreed to pay restitution to consumers from overpaid out-of-pocket expenses, claims wrongly denied, and interest on delayed claims. *Id.* United also agreed to develop an $800,000 public outreach campaign to educate consumers on their MH/SUD benefits. *Id.*; *see also UPMC hit with $250K claims notification penalty*, BECKER'S PAYER ISSUES (Jan. 4, 2022), www.beckerspayer.com/payer/upmc-hit-with-250k-claims-notification-penalty.html [perma.cc/G7FC-9NTL] (noting Pennsylvania penalized UPMC $250,000 for a series of insurance violations, including claims processing violations, Unfair Insurance Practices Act violations, and mental health parity violations stemming from a lack of comparative analysis and improper application of QTLs/NQTLs).

331. *Id.*

332. *State Parity Implementation Survey*, *supra* note 303.

333. *See* Shana, *supra* note 89 ("Countries with a single-payer health care system often see the value in providing mental health care, and consequently, have fewer parity problems than the United States").

334. *See* Paige Minemyer, *UnitedHealth Was 2021's Most Profitable Payer. Here's a Look at What its Competitors Earned*, FIERCE HEALTHCARE (Feb. 11, 2022, 1:00 PM), www.fiercehealthcare.com/payers/unitedhealth-was-2021s-most-profitable-payer-heres-look-what-its-competitors-earned [perma.cc/R9YG-8ZLD] (stating 2021 profits reported are as follows: UnitedHealth Group – $17.3B, CVS Health – $7.9B, Anthem – $6.1B, Cigna – $5.4B, Humana – $2.9B, and Centene – $1.3B).

335. *See Market Share of Leading Health Insurance Companies in the United States as of 2022*, STATISTA, www.statista.com/statistics/761446/leading-us-health-insurers-in-the-us-covered-lives [perma.cc/56SF-5B54] (last visited Nov. 12, 2022) (stating the percent market share as of 2022 for leading health insurance companies is as follows: UnitedHealth Group – 12%, Anthem – 11%, Centene – 10%, Humana – 7%, Health Care Services Corporation – 6%, CVS Health – 5%, Molina Healthcare – 2%, Cigna – 2%, Kaiser – 2%, GuideWell – 2%).

to provide additional coverage would be "price noncompetitive."[336] In the end, the denial of necessary treatment negatively impacts consumers, who are left without protection. Accordingly, this section will provide suggestions for closing the gaps in federal and state parity law and improving parity enforcement in a consistent and uniform manner.

A. Closing the Gaps in Parity Law

Parity law has come a long way since President John F. Kennedy first imposed equivalent standards in federal employee health plans.[337] However, key coverage gaps remain. This section provides suggestions for closing the major gaps in the Federal Parity Law, including requiring coverage of certain behavioral health conditions, uniformly defining MH/SUD, and standardizing medical necessity criteria. Additionally, this section provides ways in which states may continue to strengthen their own parity regulations.

1. The Federal Parity Law Should be Amended to Require Coverage of Certain Behavioral Health Conditions

A core set of behavioral health conditions should be identified that are required to be covered by all health plans under the Federal Parity Law. For example, California requires issuers to cover nine conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.[338] For children, California goes beyond these nine conditions to require coverage for any disorder identified in the most recent edition of the DSM, except substance use and developmental disorders that result in inappropriate behavior when compared to developmental norms. [339] Other states have imposed different behavioral health coverage mandates.[340]

336. *See* Don Sapatkin, *With New Report, Biden Administration Takes on Insurers Over Mental Health Failings*, MIND SITE NEWS (Jan. 26, 2022), www.mindsitenews.org/2022/01/26/with-new-report-biden-administration-takes-on-insurers-over-mental-health-failings [perma.cc/75WG-3N5G] (noting that an issuer provided exclusion analysis that was "ludicrous. It's one page, and it says: 'We're excluding ABA because every other plan does it.'"); *see also A Family's Struggle to Care for Son's Autism, supra* note 55 (stating that for the issuer to cover ABA treatment would be "price noncompetitive" because competitors don't cover it).

337. Barry et al., *supra* note 61.

338. *California Parity Report*, PARITYTRACK, www.paritytrack.org/reports/california [perma.cc/6H4W-K5X9] (last visited Nov. 19, 2022).

339. *Id.*

340. *See, e.g.*, 215 ILL. COMP. STAT. 5/370c, *supra* note 204 (requiring health issuers to cover medically necessary treatment for MH/SUD, but not specific

Further research should be developed to identify the appropriate core set of behavioral health conditions based on severity, prevalence, risk of discrimination, and societal impact, including any variations for children.

Currently, self-insured health plans are free to choose whether they cover certain behavioral health conditions.[341] Amending the Federal Parity Law to require coverage of a core set of conditions would provide consistency across plans, increasing the transparency of coverage determinations and providing additional consumer protections against arbitrary denials of coverage.

For fully-insured health plans, the ACA has identified MH/SUD coverage as an essential benefit.[342] However, similar to the Federal Parity Law, the ACA does not require certain conditions to be covered.[343] Instead, the ACA allows issuers to choose from one of four EHB benchmark plans, resulting in variations in behavioral health coverage by state and within a single state.[344] Amending the Federal Parity Law to require coverage of a core set of behavioral health conditions would remedy these inconsistencies.

Finally, requiring coverage of a core set of behavioral health conditions strikes an appropriate balance between consumer protections and issuer discretion. All issuers would be required to cover the same set of behavioral health conditions, eliminating the risk of becoming noncompetitive due to more generous coverage offerings. To the contrary, Evernorth, a subsidiary of Cigna, found that health care costs can decrease by more than $3,000 per person over two years for those diagnosed with a behavioral health condition if they receive outpatient treatment.[345] These savings offset the cost of behavioral health care, yielding a positive return on investment (ROI).[346]

Although issuers would be required to cover these conditions, they would only be required to cover treatment when medically necessary. Issuers would retain discretion for determinations of

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conditions)

341. Barry et al., *supra* note 61.

342. *Ten Essential Health Benefits*, supra note 117.

343. *Mental Health & Substance Abuse Coverage*, *supra* note 118.

344. *See* Pestaina, *supra* note 88 (stating the four EHB benchmark plan options include "(1) any of the three largest state employee plan health benefit options, (2) the largest plan in any of the three largest small group insurance market products, (3) any of the three largest national Federal Employee Health Benefit Program (FEHBP) national plan options, and (4) the coverage offered by the largest insured commercial non-Medicaid HMO in the state.").

345. *See Behavioral Health Treatment Helps Reduce Total Cost of Care, New Evernorth Analysis Finds*, EVERNORTH (Nov. 16, 2021), www.evernorth.com/articles/behavioral-health-treatment-helps-reduce-total-cost-care-new-evernorth-analysis-finds [perma.cc/3LHQ-YDWJ] (analyzing "medical, behavioral, and pharmacy claims data for 275,000 customers over four years who were newly diagnosed with a behavioral health condition, such as anxiety, depression, or substance use disorder").

346. *Id.*

duration, facility-type, and any other limitations so long as the limitation is applied no more restrictively than it is to med/surg coverage. At the same time, consumers would be assured that core behavioral health conditions are covered regardless of the health plan they are enrolled in.

2. *The Federal Parity Law Should be Amended to Define MH/SUD*

As regulators suggest in the 2022 Report to Congress, the Federal Parity Law should be amended to define MH/SUD consistent with the most current version of the DSM or ICD.[347] A standardized definition of MH/SUD conditions ensures it is defined in an objective and uniform fashion, consistent with external benchmarks based on nationally recognized standards.[348] A standardized definition also reduces the risk that issuers will erroneously define a disorder as med/surg in order to remove it from MH/SUD parity protections.

True, the DSM and ICD define MH/SUD conditions differently.[349] While the DSM is most prevalent in the U.S. and for research around the world, the majority of psychiatrists outside the U.S. rely on the ICD.[350] There have been recent efforts to align these two classification systems.[351] In the future, it may be beneficial to identify a single source for defining MH/SUD under the law. However, additional clinical and market research would be needed to identify which national standard is best suited for the U.S. insurance market. At present, even reducing the classification of MH/SUD to two sources would make a meaningful difference in reducing the number of non-uniform, subjective coverage determinations. Additionally, nationally recognized standards evolve over time, encouraging the use of up-to-date evidentiary findings for behavioral health classifications.[352]

A standardized definition of MH/SUD also positively impacts parity enforcement. Having a consistent MH/SUD classification system would allow consumers, providers, issuers, and regulators to more easily evaluate whether a violation of parity has occurred due to a misclassification.[353] A standardized definition would also streamline the NQTL comparative analyses, since what is considered a MH/SUD condition would remain consistent across

347. *2022 Report to Congress*, *supra* note 53, at 53.

348. *Id.*

349. First et al., *supra* note 212.

350. *Id.*

351. *See id.* (noting the alignment of the two classifications reached its peak with ICD-8 and DSM-II). This alignment was driven from the close collaboration between the two sponsoring organizations. *Id.*

352. Pestaina, *supra* note 88.

353. *Id.*

plans and states.[354]

3. *The Federal Parity Law Should be Amended to Require Medical Necessity Determinations Consistent with Generally Accepted Standards of Care*

Currently, issuers have full discretion in determining medical necessity. The Federal Parity Law should be amended to require medical necessity criteria to be consistent with generally accepted standards of care.

For SUD, the Federal Parity Law should be amended to require the use of ASAM criteria for determining medical necessity. ASAM criteria is the "most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions."[355] The ASAM criteria has been rigorously tested and accepted by at least eleven states.[356] CMS has identified the ASAM criteria as evidence-based treatment guidelines.[357] In *Wit*, all parties' expert witnesses agreed that ASAM criteria was aligned with generally accepted standards of care.[358] Accordingly, the Federal Parity Law should be amended to require the use of ASAM criteria for SUD medical necessity determinations.

For MH disorders, the Federal Parity Law should be amended to require the use of medical necessity criteria developed by a nonprofit clinical professional association, such as Level of Care Utilization System ("LOCUS"), Child and Adolescent Level of Care Utilization System ("CALOCUS"), Child and Adolescent Service Intensity Instrument ("CASII"), or Early Childhood Service Intensity Instrument ("ECSII"). In *Wit*, all parties' expert witnesses agreed that these criteria were aligned with generally accepted standards of care.[359] There may be an opportunity to streamline these criteria into a single accepted standard. However, additional clinical and market research would be needed.

Amending the Federal Parity Law to require the use of

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354. *Id.*

355. *What is the ASAM Criteria?*, AM. SOCIETY OF ADDICTION MEDICINE, www.asam.org/asam-criteria/about-the-asam-criteria [perma.cc/MJS7-WGH9] (last visited Nov. 16, 2022).

356. *Spotlight on Medical Necessity Criteria for Substance Use Disorders*, *supra* note 232; *see also* David Mee-Lee & Gerald R. Shulam, *The ASAM Placement Criteria and Matching Patients to Treatment*, PAUL EARLEY, www.paulearley.net/articles/asam-criteria/asam-textbook-chapter-4-5?showall=1 [perma.cc/4TG5-DWPP] (last visited Feb. 25, 2023) (excerpt from *Principles of Addiction Medicine, Third Edition*); ABIGAIL J. HERRON & TIM K. BRENNAN, THE ASAM ESSENTIALS OF ADDICTION MEDICINE 16-27 (3d ed. 2013).

357. *Spotlight on Medical Necessity Criteria for Substance Use Disorders*, *supra* note 232.

358. *Wit*, 2020 U.S. Dist. LEXIS 205435, at *56-57.

359. *Id.*

generally accepted standards of care would drastically increase patient protections by shielding against arbitrary insurance denials derived from internally developed medical necessity criteria. It will ensure all parties are "speaking the same language" and promote transparency in coverage determinations.[360] By using a national standard, medical necessity criteria will also evolve as research progresses.

Finally, standardized medical necessity criteria will lighten the burden of parity enforcement, as there would no longer be a need to rely on the issuers to disclose their internal medical necessity criteria.[361]

4. States Should Continue to Strengthen Parity Regulations

States should continue to adopt legislation to strengthen parity regulations, including the implementation of behavioral health coverage mandates, standardization of medical necessity criteria, and adoption of mandatory parity compliance reporting. States can leverage the template legislation that has been developed by non-profit organizations, including the American Psychiatric Association ("APA") and The Kennedy Forum, to advance parity legislation.[362] Additionally, states should continue to educate consumers on their right to parity and take steps towards eradicating the stigma surrounding MH/SUD conditions.

B. Improving Enforcement of Federal and State Parity Law

Enforcing parity creates a unique challenge – it requires detailed comparative analyses that can only be completed using data possessed by the very entity that is subject to the investigation.[363] Regulators, issuers, providers, and consumers have all expressed challenges with the enforcement of parity. Thus, ERISA should be amended to grant the DOL authority to impose civil penalties for parity violations, and that additional federal funding and guidance be distributed to enhance parity enforcement efforts.

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360. Guyer et al., *supra* note 239, at 9.

361. Pestaina, *supra* note 88.

362. *See, e.g.*, *Insurance Coverage and Model Legislation*, *supra* note 299 (providing model parity legislation for reporting requirements, commissioner implementation requirements, and coverage for medication-assisted treatment for SUD); *Jim Ramstad Model State Legislation to Advance Mental Health and Addiction Equity By Requiring Compliance with Generally Accepted Standards of Care*, THE KENNEDY F. (May 2021), www.thekennedyforum.org/app/uploads/2021/05/Ramstad-Model-Legislation-May-2021.pdf [perma.cc/FPW2-PANG] (providing model parity legislation for generally accepted standards of care).

363. *2022 Report to Congress*, *supra* note 53, at 51-52.

1. *ERISA Should Be Amended to Grant the DOL With the Authority to Impose Civil Monetary Penalties*

As regulators suggest in the 2022 Report to Congress, ERISA should be amended to grant the DOL authority to assess civil monetary penalties for parity violations.[364] The DOL already has similar authority to impose civil penalties for the enforcement of other group health plan restrictions, such as the prohibition against using genetic information to discriminate against enrollees.[365]

The ability to impose penalties will incentivize compliance and shift the focus away from retroactive remedial actions.[366] Often times, MH/SUD coverage is denied, the denial is challenged, and an investigation is opened, which can take years to complete.[367] In the meantime, the individual is forced to appeal the denial, forego care, or pay out-of-pocket in hopes of eventually being reimbursed.[368] Parity should not work backwards – the goal is to never put the individual in that position in the first place. To alter the reactionary practices of MH/SUD parity, the DOL must have the ability to hold issuers and administrators accountable by imposing its own civil penalties.

2. *Additional Federal Funding and Guidance Should be Distributed*

There remains a need for additional federal funding and guidance to enhance parity enforcement. States and agencies have emphasized the beneficial effect of federal grants for parity enforcement – including the ability to engage experts, complete market conduct exams, train staff, and educate the public on parity.[369] Parity enforcement is both time- and resource-intensive.[370] In 2023, the EBSA allocated nearly twenty-five percent of its enforcement program to federal parity compliance.[371]

364. *Id.*

365. 29 U.S.C. § 1132(c)(10); *see also DOL Increases Civil Money Penalties for 2022, Effective January 15, 2022*, WESTLAW (Jan. 14, 2022), www.content.next.westlaw.com/practical-law/document/I39032956748a11ec9f24ec7b211d8087/DOL-Increases-Civil-Money-Penalties-for-2022-Effective-January-15-2022?viewType=FullText&transitionType=Default&contextData=(sc.Default) [perma.cc/M7FH-PMZD] (listing DOL penalty amounts for 2022).

366. *2022 Report to Congress*, *supra* note 53, at 52.

367. *Id.*

368. *Id.*

369. *A Review of State Efforts to Enforce Mental Health Parity*, *supra* note 308, at 12

370. *Id.*; *see also 2023 Comparative Analysis Report to Congress*, *supra* note 114, at 53, 66 (noting investigations often involve "interviews, depositions, document requests, data requests, and subpoenas" as well as conferences).

371. *2023 Comparative Analysis Report to Congress*, *supra* note 114, at 23.

Increased funding would allow regulatory authorities and states to increase their manpower and escalate their enforcement efforts.

Additionally, both regulators and issuers have asked for additional guidance on parity requirements, specifically related to the NQTL comparative analyses.[372] All parties have appreciated the examples of compliance and case studies provided, with one regulator stating, "you can never have enough of them."[373] Additional guidance and examples should be provided for completed NQTL analyses. Also, additional guidance should be provided for behavioral health conditions that are commonly denied or difficult to compare with med/surg due to a lack of a logical equivalent. Additional guidance will help clarify regulations and promote transparency in parity enforcement.

V. CONCLUSION

Fourteen years have passed since the Federal Parity Law was enacted.[374] The prevalence of MH/SUD is at an all-time high.[375] The nation is in the midst of a mental health crisis, with fragmented laws and enforcement that lacks strength and accountability.[376]

Crucial coverage gaps have become increasingly evident in the Federal Parity Law, including no requirement for behavioral health conditions to be covered, lack of a standardized definition for MH/SUD conditions, and far-reaching variations in medical necessity criteria. Some states have taken it upon themselves to fill these holes, while others have remained stagnant.

State and federal regulators have expressed deep concerns with the ability to enforce parity. States lack the time and resources needed for adequate enforcement, and the DOL is left with the ability to identify violations, but no ability to punish them. Worst of all, consumers are left to "fend for themselves" and have paid with their lives.[377]

Until regulations are expanded and enforcement is improved, MH/SUD parity law remains elusive, unable to rectify the disjointed health insurance system, and placing millions of individuals' lives at risk.

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372. *Id.*
373. *Id.*
374. *See* 29 U.S.C. § 1185a (2013).
375. *America's Mental Health Crises*, *supra* note 52.
376. *Id.*
377. Schatt-Denslow, *supra* note 5.