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## Enforcing Mental Health Parity Through the Affordable Care Act's Essential Health Benefit Mandate\*

*Kathleen G. Noonan<sup>†</sup> and Stephen J. Boraske<sup>‡</sup>*

“So many people have worked so many years to get us this far, but we are starting all over again. The new mission is oversight and implementation and enforcement of MHPAEA.” Patrick J. Kennedy, Former U.S. Congressman (December 6, 2013).

### I. INTRODUCTION

In recent years, advocates for expanded mental health benefits secured two successes in fundamental coverage.<sup>1</sup> First, Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (“MHPAEA”)<sup>2</sup> in 2008, ushering in new, equitable insurance protections for Americans with mental health (“MH”) and substance use (“SU”) disorder afflictions. Second, in 2010 the Patient Protection and Affordable Care Act (“ACA”)<sup>3</sup> expanded health insurance coverage to millions of uninsured Americans and required that any health plans sold on the newly created insurance federal and state marketplaces (the “marketplace”) include mental health and substance abuse coverage as “essential health benefits (“EHB”).<sup>4</sup>

Before the enactment of these laws, the federal government deferred to state insurance commissioners and payers on whether and how mental

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1. See Emergency Economic Stabilization Act of 2008, Pub L. No. 110-343, sec. 511–12, 122 Stat. 3756, 3881–92 (codified as amended at 29 U.S.C. § 1185a (2009) and 42 U.S.C. § 300gg-26 (2008)) [hereinafter MHPAEA or the parity law]. See also Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of U.S.C.) [hereinafter ACA or the healthcare law].

2. MHPAEA § 511-512.

3. ACA, 124 Stat. 119.

4. *Id.* §1302(b)(1) (codified at 42 U.S.C. § 18022).

health benefits would be covered in commercial insurance plans.<sup>5</sup> Despite these unprecedented legislative successes, to date there has been little recorded oversight or enforcement of either parity law.<sup>6</sup> This article exposes this problem and proposes a solution using the new mental health benefit under the ACA. Specifically, because the federal government is jointly enforcing the ACA *with* states (in contrast to MHPAEA, which is delegated largely *to* states), we suggest that the enforcement of mental health parity should focus on the mental health benefit required through plans sold through marketplaces.

Though one in five Americans aged eighteen or older suffers from mental illness,<sup>7</sup> and nearly ten percent struggle with some form of alcohol use disorder or drug addiction,<sup>8</sup> health insurance coverage for these candidates is limited.<sup>9</sup> Access to proper mental health treatment has been difficult and expensive to obtain,<sup>10</sup> in part because health insurers have historically limited these benefits.<sup>11</sup> As a result, some states responded with laws and regulations intended to ensure equitable MH and SU coverage for their citi-

5. See Nat'l Conf. of State Legs., *State Laws Mandating or Regulating Mental Health Benefits*, <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> (last updated Jan. 2014)

(noting that many private insurers provided inadequate or no mental health benefits and “[t]he law [MHPAEA], the new rules and provisions of Obamacare [ACA] combined will ensure mental and physical illness would be covered similarly.”).

6. Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE U. L. REV. 179, 230 (2013).

7. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS. RESULTS FROM THE 2010 NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH FINDINGS 7 (Jan. 2012), available at [http://www.samhsa.gov/data/sites/default/files/2k10MH\\_Findings/2k10MH\\_Findings/2k10MHResults.pdf](http://www.samhsa.gov/data/sites/default/files/2k10MH_Findings/2k10MH_Findings/2k10MHResults.pdf).

8. See NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM, U.S. DEP'T OF HEALTH & HUM. SERVS., ALCOHOL AND OTHER DRUGS 1 (July 2008), available at <http://pubs.niaaa.nih.gov/publications/AA76/AA76.pdf>.

9. See Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 405 (2010); See PARITY IMPLEMENTATION COALITION, PARITY TOOLKIT FOR ADDICTION & MENTAL HEALTH CONSUMERS, PROVIDERS & ADVOCATES (1st ed. Sept. 2010), available at <http://parityispersonal.org/sites/default/files/pdfs/Parity%20Toolkit.pdf>.

10. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., AFFORDABILITY MOST FREQUENT REASON FOR NOT RECEIVING MENTAL HEALTH SERVICES (Sept. 24, 2013), available at <http://www.samhsa.gov/data/sites/default/files/spot075-services-affordability-2013/spot075-services-affordability-2013.pdf> (finding that “cost/insurance issues (e.g., not being able to afford care or lacking insurance coverage) were the most frequently mentioned reasons for not receiving mental health services”).

11. PARITY IMPLEMENTATION COALITION, *supra* note 9, at 6 (“Most Americans with health insurance face greater barriers in accessing services for mental illness and addiction than they face for accessing care for other medical conditions. The majority of health plans impose higher out of pocket spending requirements and more restrictive treatment limitations on addiction and mental health benefits.”).

zens.<sup>12</sup> At the federal level, the MHPAEA passed in 2008, and requires certain insurance plans to offer MH/SU benefits at parity with surgical/medical benefits, with respect to financial requirements and treatment limitations.<sup>13</sup> However, the MHPAEA has an Achilles heel: it does not require insurance plans to cover mental health services.<sup>14</sup> Specifically, the parity mandate applies only to insurance providers that *choose* to offer MH/SU benefits in addition to medical/surgical coverage.<sup>15</sup> Some insurance plans report they dropped their MH/SU benefits to avoid compliance with the MHPAEA.<sup>16</sup> Thus, MHPAEA's loophole swallowed its goal: "parity" with nothing would always be nothing. Moreover, the real issue is not lack of MH coverage, but substandard coverage.

The ACA harbors no such weakness. In order to sell "qualified health plans" ("QHP") on the new Exchanges created by the ACA, providers must cover MH and SU disorder benefits as part of an EHB package mandated by the healthcare law.<sup>17</sup> Thus, every individual and small market group plan offered through the Exchanges must cover MH and SU treatment services.<sup>18</sup> Read together, the ACA and MHPAEA create, for the first time, an

12. See Nat'l Conf. of State Legs., *supra* note 5 (noting that 49 states and the District of Columbia have enacted some kind of mental health benefit law).

13. MPA Pub L. No. 110-343, sec. 512(a), 122 Stat. 3756, 3881-92 (codified as amended at 29 U.S.C. § 1185a (2009) and 42 U.S.C. § 300gg-26 (2008)) (defining "parity" to mean that the financial requirements and treatment limitations can be no more restrictive than the predominant requirements and limitations placed on medical/surgical benefits). See NAT'L ASS'N OF INS. COMM'RS, NAIC FORM REVIEW WHITE PAPER 10 (2012), available at [http://www.naic.org/documents/committees\\_b\\_related\\_wp\\_form\\_review.pdf](http://www.naic.org/documents/committees_b_related_wp_form_review.pdf) [hereinafter NAIC FORM].

14. E.g., Ctr. for Consumer Info. & Ins. Oversight, *The Mental Health Parity and Addiction Equity Act*, CMS.GOV, [http://cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea\\_factsheet.html](http://cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (last visited Nov. 17, 2014).

15. See *infra* Part III.B for complete details on the provisions of the MHPAEA.

16. See KAISER FAMILY FOUND., HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS - 2010 ANNUAL SURVEY 7 (2010), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8085.pdf>.

17. ACA Pub L. No. 111-148, § 1302(b)(1), 124 Stat. 119 (2010) (codified as amended in scattered sections of U.S.C.) (The ACA provides a list of broad benefit classes that must be included in each state's "base" benchmark plan, and subsequently, any EHB-governed plan in the state. The benefit classes include: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.). See also Grace et al., *The ACA's Pediatric Essential Health Benefit Has Resulted In A State-By-State Patchwork Of Coverage With Exclusions*, 12 HEALTH AFFAIRS 2136, 2136-37 (discussing EHBs and state "base" benchmark plans).

18. ACA § 1304(a)(1) (defining a group market as "the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a [small] employer."); *Id.* § 1304(a)(2) (defining an individual market as "the market for health insurance coverage offered to individuals other than in connection with a group health

enforceable coverage-parity mandate for MH and SU disorder benefits.<sup>19</sup>

Scholars have repeatedly observed that the law as written is not the same as the law in action, and enforcement determines the difference between the two.<sup>20</sup> The ACA-MHPAEA parity mandate is therefore only as good as its enforcement. Yet, MHPAEA enforcement efforts have largely been carried out by private parties contesting specific benefits under their own plans, rather than by public authorities administering a consistent and highly visible enforcement regime.<sup>21</sup> Similarly, at the time of this writing, the ACA has no published enforcement decisions regarding the mental health benefit required in QHPs.<sup>22</sup>

This article argues that the current MHPAEA enforcement regime is ineffective, and proposes an alternative and more unified model using the ACA's QHP compliance mechanism. Enforcement of the MHPAEA should begin by standardizing EHB definitions through the ACA, followed by certification and monitoring of QHPs offered on Exchanges.<sup>23</sup>

The United States Department of Health and Human Services ("HHS"), the agency responsible for the implementation of the ACA, has indicated that it may revisit EHB definitions for the 2016 plan year.<sup>24</sup> Thus, the opportunity to establish a robust set of national standards related to mental health benefits is ripe. These standards could serve as a coverage floor for

plan.”).

19. See, e.g., Suann Kessler, *Mental Health Parity: The Patient Protection and Affordable Care Act and the Parity Definition Implications*, 6 HASTINGS SCI. & TECH. L.J. 145, 159 (2014). See also Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 42 (2012); Weber, *supra* note 6, at 179 (“Beginning in 2014, all health plans regulated by the Affordable Care Act must also comply with parity standards, effectively ending the second-class insurance status of persons with these disorders.”).

20. Margaret H. Lemos, *State Enforcement of Federal Law*, 86 N.Y.U. L. REV. 698, 699 (2011) (citing Roscoe Pound, *Law in Books and Law in Action*, 44 AM. L. REV. 12 (1910), reprinted in AMERICAN LEGAL REALISM 39, 39–40 (William W. Fisher III, Morton J. Horwitz, & Thomas A. Reed eds., 1993)).

21. See *infra* Part III for a discussion of different approaches to enforcement of federal law; see also *infra* Part IV.B for a discussion of MHPAEA enforcement efforts to date.

22. See ACA, Pub L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of U.S.C.).

23. Ctr. For Consumer Info. & Ins. Oversight, *State Health Insurance Marketplaces*, CMS.GOV (Oct. 30, 2013), <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html>. Currently there are 14 SBES, 7 SPEs, and 27 FFEs. KAISER FAMILY FOUND., *State Decisions for Creating Health Insurance Marketplace Types, 2015* (2014), <http://kff.org/health-reform/state-indicator/health-insurance-exchanges> (providing that the ACA and subsequent regulations permit the establishment of three kinds of Exchanges in each state: a State-based Exchange (SBE); a Partnership-based Exchange (SPE); and a Federally-facilitated Exchange (FFE)).

24. Center for Consumer and Insurance Oversight, *Essential Health Benefits Bulletin* [Internet]. Baltimore (MD) Centers for Medicare and Medicaid Services; 2011 Dec 16 [cited 2014 October 10], available at [https://www.cms.gov/ccio/resources/files/downloads/essential\\_health\\_benefits\\_bulletin.pdf](https://www.cms.gov/ccio/resources/files/downloads/essential_health_benefits_bulletin.pdf).

all health plans available through Exchanges.<sup>25</sup> This article contributes to that effort.

The remainder of this article proceeds in five parts. Part II provides background on the role of the federal government and states in health insurance regulation and enforcement. Part III includes an overview of the ACA and MHPAEA; specifically, a description of their enforcement provisions. Part IV details the criticism of the MHPAEA's weak enforcement mechanism, as well as existing public and private enforcement efforts undertaken to date. Part V explains how the ACA and MHPAEA interact to create a new coverage-parity mandate, and then proposes a new model for enforcing the MHPAEA through the ACA's EHB definitions and compliance mechanisms. Part VI concludes.

## II. REGULATING HEALTH INSURANCE IN THE FEDERALIST PARADIGM

The United States health insurance system presents a unique and complex challenge for legislators and regulators, especially in the context of our federalist roots.<sup>26</sup> Congress, state legislatures, and federal and state regulatory agencies all play a role in monitoring and enforcing healthcare law.<sup>27</sup> This concept of “concurrent enforcement”—wherein federal and state authorities share responsibility for enforcement of national policy—has sparked much scholarly attention of late.<sup>28</sup> The issue is especially prevalent in the area of healthcare law and insurance, given the enactment of the ACA in 2010 and its joint implementation by the federal government and states.<sup>29</sup>

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25. See *infra* Part 0 (identifying the statutory and regulatory basis for enforcement of both the parity law and healthcare law). See also *infra* Part 0 (reviewing the limited MHPAEA enforcement efforts to date, demonstrating the challenges private actors still face in obtaining equitable coverage, and the overall ineffectiveness of the current enforcement regime); *infra* Part 0, Appendix A (exploring the limits and exclusions all 50 states and the District of Columbia placed on their MH/SU benefits in their 2012 EHB-benchmark plans, which are similar to enforcement of the MHPAEA, because the HHS Secretary deferred to both states and payers in defining the MH/SU essential health benefit, and broad variability exists in coverage).

26. See generally Amanda M. Rose, *State Enforcement of National Policy: A Contextual Approach (with Evidence from the Securities Realm)*, 97 MINN. L. REV. 1343 (2013) (discussing how power should be separated between the states and federal government to conserve federalism).

27. See *id.* at 1351 (explaining that the state and federal government often work together to enforce laws in the United States).

28. E.g., *id.* at 1344 (citing Rachael E. Barkow, *Insulating Agencies: Avoiding Capture Through Institutional Design*, 89 TEX. L. REV. 15, 56–57 (2010), and Lemos, *supra* note 20, at 699–04).

29. See SARAH ROSENBAUM & DAVID M. FRANKFORD, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 223 (2d ed. 2012) (discussing the ACA's impact on “cooperative federalism”).

### A. Regulation of Commercial Health Insurance

Generally speaking, states regulate insurance in the United States.<sup>30</sup> State legislatures, acting as public policymakers, enact legislation that provides the regulatory framework under which insurance departments operate.<sup>31</sup> These departments typically prohibit the sale of insurance by anyone who has not obtained a license from the state insurance department.<sup>32</sup> Government authorities heavily regulate the insurance industry mainly because of the complexity of insurance contracts and because consumers have very little involvement in the negotiation of plan terms.<sup>33</sup> Insurance regulation is often divided into six main functional divisions: licensing (of insurance companies), taxation, pricing rates, solvency, forms, access and availability, and market conduct.<sup>34</sup>

State control of insurance regulation has been affirmed both by the United States Supreme Court and in various federal statutes.<sup>35</sup> In the mid-1800s, state legislatures began creating independent administrative agencies to supervise insurance activity in their states.<sup>36</sup> Some early insurance issuers challenged state control of insurance regulation.<sup>37</sup> The Supreme Court would eventually hear this challenge after an insurance broker, licensed in New York, was indicted for selling an insurance policy in Virginia.<sup>38</sup> The Court rejected the broker's challenge to the validity of the Virginia law and concluded that states were the primary regulators of insurance, not the federal government.<sup>39</sup> This ruling placed the burden of insurance regulation squarely with states and beyond the reach of Congress.<sup>40</sup>

However, the Supreme Court changed its position. In 1944, the Court overruled its earlier decision in *Paul v. Virginia* and held in *United States v. South-Eastern* that insurance was interstate commerce and therefore subject to federal regulation:

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30. See, e.g., TOM BAKER, *INSURANCE LAW AND POLICY* 651 (2008) (noting that this “is at least in part the result of a long history of state regulation dating to the mid-nineteenth century”).

31. NAT'L ASS'N OF INS. COMM'RS, *STATE INSURANCE REGULATION* 2 (2011), available at [http://www.naic.org/documents/topics\\_white\\_paper\\_hist\\_ins\\_reg.pdf](http://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf).

32. BAKER, *supra* note 30, at 637.

33. NAT'L ASS'N OF INS. COMM'RS, *supra* note 31.

34. BAKER, *supra* note 30, at 637.

35. McCarran-Ferguson Act, Pub. L. No. 79-15, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015 (2006)); see, e.g., *Paul v. Virginia*, 75 U.S. 168, 170 (1869) (holding that insurance is not interstate commerce and therefore cannot be regulated at the federal level).

36. BAKER, *supra* note 30, at 652.

37. *Id.* at 652–53.

38. *Paul*, 75 U.S. at 170.

39. *Id.* (concluding that “issuing a policy of insurance is not a transaction of commerce”).

40. *Id.* at 183; see also BAKER, *supra* note 30, at 652–53.

Our basic responsibility in interpreting the Commerce Clause is to make certain that the power to govern intercourse among the states remains where the Constitution placed it. That power, as held by this Court from the beginning, is vested in the Congress, available to be exercised for the national welfare as Congress shall deem necessary. No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.<sup>41</sup>

By this point, state regulation of insurance was widely accepted and the industry's reaction to the decision was largely negative.<sup>42</sup>

Congress responded to *South-Eastern* by enacting the McCarran-Ferguson Act one year later.<sup>43</sup> The Act exempted the "business of insurance" from federal regulation, and permitted states to mandate certain regulatory requirements.<sup>44</sup> Federal law would only supersede state law where it directly related to the business of insurance.<sup>45</sup> In the same year, Congress enacted the Public Health Services Act ("PHSA"), which declared that states are the primary enforcement authority over health insurance issuers.<sup>46</sup>

Few authorities question the basic assumption that states are the primary regulators of insurance. Nevertheless, the history of insurance regulation has been marked by ongoing federal-state tensions.<sup>47</sup> The federal government's role in health insurance became more complex when it became a payer in 1965 through the creation of the Medicare and Medicaid programs.<sup>48</sup> As a result, both state and federal government heavily regulate insurance.<sup>49</sup> At the state level, this regulation manifests in part through the

41. *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 552–53 (1944).

42. *See* BAKER, *supra* note 30, at 654 (noting that the "decision was viewed as an assault on state regulatory and tax authority over the industry").

43. *See* McCarran-Ferguson Act, 15 U.S.C.A. § 1011 (West, WestlawNext current through P.L. 113-180).

44. BAKER, *supra* note 30, at 654.

45. *Id.*

46. Public Health Services Act, 42 U.S.C.A. § 300gg-22(a)(1) (West, WestlawNext current through P.L. 113-180).

47. Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 626 (1999).

48. *See* Social Security Act, 42 U.S.C.A. § 1396b(a) (West, WestlawNext current through P.L. 113-180 (explaining how the government shall pay the states with Medicare and Medicaid plans).

49. At the federal level, the Employee Retirement and Income Security Act (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 and 29 U.S.C.), preempts most state laws that regulate private employee benefit agreements, and it expressly preempts state law remedies. *See* Brendan S. Maher, *Thoughts on the Latest Battles over ERISA's Remedies*, 30 HOFSTRA LAB. & EMP. L.J. 339, 353 (2013). ERISA governs "employee welfare benefit plans," which include plans established by employers for the pur-



existence of state-mandated benefit laws.<sup>50</sup> As observed by the National Conference of State Legislatures, “[f]or more than two decades, state legislators have regularly debated and enacted ‘mandates’ or required health coverage for specific treatments, benefits, providers and categories of dependents.”<sup>51</sup> These mandated benefit statutes typically require coverage for certain types of care, such as treatment related to mental illness or substance abuse, childhood immunizations, maternity care, and other services.<sup>52</sup> There are more than 1,900 such statutes among all fifty states.<sup>53</sup>

This joint federal-state paradigm means states are routinely enforcing national legislation or policies either independently or concurrently in exchange for federal program funding and program support.<sup>54</sup> State interest in doing so varies, of course, depending on a number of factors including capacity issues, financing incentives, and politics.<sup>55</sup> The question of how to effectively implement and allocate enforcement authority between the two layers of government is highly complex and one of perennial debate.<sup>56</sup>

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pose of providing medical, surgical, or hospital care benefits to beneficiaries through the purchase of insurance. 29 U.S.C.A. § 1002(1) (West, WestlawNext current through P.L. 113-180). Some 175 million workers and their families are covered through an ERISA-governed health plan. ROSENBAUM, *supra* note 29, at 259. As a result of ERISA, certain kinds of employee benefit plans, including those offering health benefits, do not have to comply with state insurance laws. Janet E. Kaminski, *Self-Insured Benefit Plans and Insurance Mandates*, OLR RESEARCH REPORT (2005). ERISA contains three important clauses that implement federalist principles and work together to remove most denial of benefit claims to federal court. The *preemption clause* states that ERISA provisions “shall supersede . . . State laws” to the extent that those laws “relate to any employee benefit plan.” 29 U.S.C. § 1144(a) (West, WestlawNext current through P.L. 113-180). The *savings clause* accepts from the preemption clause state laws that regulate insurance. *Id.* § 1144(b)(2)(A). The *deemer clause* makes clear that a state law that purports to regulate insurance cannot deem an employee benefit plan to be an insurance company. *Id.* § 1144(b)(2)(B). In interpreting these provisions, the Supreme Court has held that Congress intended ERISA to completely preempt any state law that expands the remedies available for a failure to provide plan benefits, even if that law regulates insurance. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 44–45 (1987). ERISA does provide civil remedies for plan enrollees who have been denied health insurance benefits, although these remedies are typically less robust than those available under state law. *See Aetna Health, Inc. v. Davila*, 524 U.S. 200, 221 (2004) (finding that no remedy for a wrongful death resulting from the improper denial of health benefits exists under ERISA).

50. Nat’l Conf. of State Legs., *Mandated Health Insurance Benefits and State Laws*, <http://www.ncsl.org/research/health/mandated-health-insurance-benefits-and-state-laws.aspx> (last updated Jan. 2013).

51. *Id.*

52. ROSENBAUM, *supra* note 29, at 206–07.

53. *State Health Insurance Mandates and the ACA Essential Benefit Provisions*, *supra* note 24.

54. *See id.*

55. *See Rose*, *supra* note 26, at 1352–55.

56. Randall, *supra* note 47, at 626–28.

### B. Private and Public Enforcement Regimes

Enforcement of any law or regulation can be grouped into two broad categories.<sup>57</sup> The first is private enforcement, which consists of private individuals or groups enforcing the law.<sup>58</sup> The second is public enforcement, carried out by governmental authorities, such as regulatory agencies or attorneys general.<sup>59</sup> There are advantages and disadvantages to both approaches.

Private enforcement seeks compensation for the alleged harm.<sup>60</sup> Potential defenders in healthcare lawsuits, including providers and payers, see the cost of litigation alone as a deterrent.<sup>61</sup> However, private enforcement can result in disparities when those without sufficient economic resources are unable to bring complaints, and the violations of a statute's provisions remain unenforced.<sup>62</sup> Additionally, private parties can be motivated by their own private interests and often ignore the costs and benefits of their efforts to others.<sup>63</sup>

Public enforcement, on the other hand, has different advantages and disadvantages. Public agencies translate legislative requirements into workable rules, centralizing principles and taking all aspects of the public's interest into account.<sup>64</sup> Public authorities tend to promote greater deterrence, given the visibility and consistency in government approach relative to disorganized private efforts.<sup>65</sup> Public enforcement also has drawbacks: notably, the scarcity of resources and the propensity of some policymakers to shy away from controversial actions or overreact to public opinion or lobbying pressures.<sup>66</sup>

Public enforcement can be broken down further depending on whether enforcement authority rests with the federal government or states.<sup>67</sup> There

57. Lemos, *supra* note 20, at 704.

58. *See id.* at 704, 706.

59. *Id.* at 704; *See infra* Part IV (for a discussion of some of the private MHPAEA enforcement efforts to date).

60. Lemos, *supra* note 20, at 706.

61. *See id.* (discussing profit motives and availability of multiple damages in private suits).

62. *See* Eloise Pasachoff, *Special Education, Poverty, and the Limits of Private Enforcement*, 86 NOTRE DAME L. REV. 1413, 1424–30 (2011) (discussing the limits of private enforcement and its ineffectiveness for low income beneficiaries).

63. Lemos, *supra* note 20, at 706.

64. *Id.* at 704–05. When enforcement proceeds through formal agency rulemaking, the public is usually more involved because of the public notice and comment procedures embedded in the federal Administrative Procedure Act and its state equivalents. *See generally* Ronald M. Levin, *Rulemaking Under the 2010 Model State Administrative Procedure Act*, 20 WIDENER L. J. 855 (2011).

65. *See* Lemos, *supra* note 20, at 705–07.

66. *Id.* at 705–06.

67. *See id.* at 717.

are many areas of regulatory and legislative concern that call for concurrent enforcement by both state and federal government.<sup>68</sup> At the federal level, enforcement tends to be more monopolistic,<sup>69</sup> allowing federal agencies to consistently control and adjust their enforcement efforts.<sup>70</sup> Additionally, while state efforts will typically be fragmented and inconsistent, the federal government often crafts coherent enforcement policies that apply across state boundaries.<sup>71</sup> State enforcement also has some advantages, as state enforcers have the benefit of local and direct knowledge of an area of regulatory concern, and allow for citizen participation in ways federal authorities cannot.<sup>72</sup>

As already noted, healthcare enforcement involves the federal government and states acting individually or jointly.<sup>73</sup> There is no single model. For example, both federal and state governments enforce the Medicaid program.<sup>74</sup> In contrast, enforcement of the Health Insurance Portability and Accountability Act (“HIPAA”) lies solely within the purview of the federal government.<sup>75</sup> The role of the federal government and states in enforcing federal health care mandates, such as the MHPAEA and the ACA, is negotiated throughout the legislative process, and similar to any law, results in compromise and settlement as legislators work towards final resolution and vote.<sup>76</sup>

### III. ENFORCEMENT UNDER MENTAL HEALTH PARITY LAW AND THE ACA

The two legislative acts that most significantly impact mental health parity today are the MHPAEA and the ACA.<sup>77</sup> The two laws interact in a number of significant ways. Generally, the ACA expands the reach of the

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68. Rose, *supra* note 26, at 1350. Besides the securities realm, another example is homeland security. *See generally* E.L. Gaston, *Taking the Gloves Off of Homeland Security: Rethinking the Federalism Framework for Responding to Domestic Emergencies*, 1 HARV. L. & POL’Y REV. 519 (2007).

69. *See* Lemos, *supra* note 20, at 717.

70. Rose, *supra* note 26, at 1353.

71. *Id.* at 1361.

72. *See generally id.* at 1357–58.

73. *See* Lemos, *supra* note 20, at 707.

74. *Federal Policy Guidance*, MEDICAID.GOV, <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html> (last visited Nov. 17, 2014).

75. *See* Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

76. *See generally The Legislative Process*, HOUSE.GOV, [http://www.house.gov/content/learn/legislative\\_process/](http://www.house.gov/content/learn/legislative_process/) (last visited Nov. 17, 2014) (providing an overview of the legislative process).

77. *See* MHPAEA, § 512(a) (codified at 29 U.S.C. § 1185(a)) (2009); *See also* ACA § 1311 (codified at 42 U.S.C.A. § 18031) (West, WestlawNext current through P.L. 113-180).

MHPAEA to a number of new kinds of health plans.<sup>78</sup> Subpart A of this section provides a brief overview of the growth of mental health parity law. Subpart B details the MHPAEA and its enforcement mechanism. Lastly, subpart C explores the ACA mental health mandate and its enforcement mechanism with the ACA.

#### A. Historical Overview of Parity Law

Prior to the passage of mental health parity legislation, many Americans seeking treatment for MH and SU problems faced high costs, significant service limitations, and other formidable barriers impeding their access to proper care.<sup>79</sup> Some individuals turned to the courts for help, arguing that their providers were using discriminatory coverage practices.<sup>80</sup> However, many courts were reluctant to strike down these policies, based on their application of contract principles to insurance plan documents.<sup>81</sup>

Efforts to achieve mental health coverage parity date back almost fifty years, and the first legislative effort to correct the problem occurred in the 1990s.<sup>82</sup> The Mental Health Parity Act of 1996 (“MHPA”) required group health plans to apply the same lifetime and annual dollar limits to mental health coverage as those applied to medical and surgical coverage.<sup>83</sup> However, the mandate applied only to plans with fifty or more employees, and did not require that mental health benefits be offered.<sup>84</sup> The final form of the law was much weaker than the original draft, and did not significantly advance mental health parity.<sup>85</sup> Additional legislative efforts at achieving

78. Amanda K. Sarata, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, CONG. RES. SERV. 1, 4 (Dec. 28, 2011), available at <http://www.ncsl.org/documents/health/MHparity&mandates.pdf>. See also *infra* Part IV for a complete discussion of the interaction between the ACA and MHPAEA.

79. See NAT’L INST. ON ALCOHOL ABUSE & ALCOHOLISM, *supra* note 8; See also SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 10; See also Barry et. al., *supra* note 9; See also Nat’l Conf. of State Legs., *supra* note 12; See also MHPAEA § 512(a) (codified at 29 U.S.C. § 1185(a)) (providing information about the challenges facing Americans with mental health and substance abuse illnesses.).

80. Sara Noel, *Parity in Mental Health Coverage: The Goal of Equal Access to Mental Health Treatment Under the Mental Health Parity Act of 1996 and the Mental Health Equitable Treatment Act of 2001*, 26 HAMLINE L. REV. 377, 380–81 (2003).

81. See *id.* (discussing how courts typically only became involved in situations where the beneficiary believed he was wrongly denied coverage because his illness had been misclassified as a mental condition, rather than a physical one).

82. Barry et al., *supra* note 9, at 408–09.

83. Mental Health Parity Act of 1996, Pub. L. No. 104-204, sec. 701-03, 110 Stat. 29442874 (codified as amended at 29 U.S.C. § 1185a (2009)) [hereinafter MHPA].

84. Barry et al., *supra* note 9, at 409.

85. Kessler, *supra* note 19, at 153–54. See also Sarah Goodell, Health Affairs Policy Brief, *Mental Health Parity 1* (Apr. 3, 2014), available at [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_112.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_112.pdf) (noting that the final version of the law “did not address treatment limits, limitations on the types of facilities covered, differences in

parity occurred in the early 2000s, but none resulted in new law.<sup>86</sup>

In 2008, Congress passed a parity law with some teeth—the MHPAEA.<sup>87</sup> This was followed by the introduction of the ACA in 2010, which dramatically overhauls much of the American health insurance coverage landscape.<sup>88</sup> The following sections discuss the enforcement provisions of the MHPAEA and ACA.

### B. Enforcement under MHPAEA

The purpose of the MHPAEA was to eliminate the differences in insurance coverage for MH and SU benefits.<sup>89</sup> The law requires group health plans and health insurance issuers to offer parity between MH and SU disorder benefits, and medical/surgical benefits with respect to financial requirements and treatment limitations.<sup>90</sup> The MHPAEA also amends the Employee Retirement Income Security Act of 1974 (“ERISA”), the PHSA, and the Internal Revenue Code.<sup>91</sup>

The MHPAEA expands the prohibition on the use of special annual and lifetime dollar limits—originally only in place for MH benefits—to include SU benefits.<sup>92</sup> Although the MHPAEA affords new protections to group health plan participants, the parity law does not mandate that a plan provide MH and SU benefits.<sup>93</sup> Rather, if a plan provides medical/surgical and MH and SU benefits, only then must the provider comply with the MHPAEA’s parity mandate.<sup>94</sup> The MHPAEA also adds new disclosure provisions for group health plans and group health insurance issuers, mandating that “medical necessity” determinations and the reason for denial of payment for services, with respect to MH/SU benefits, be disclosed to the plan partici-

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cost sharing, and the application of managed care techniques that continued to make coverage for mental health benefits less generous than coverage for other health benefit”).

86. Kessler, *supra* note 19, at 155 (discussing the Mental Health Equitable Treatment Acts of 2001, 2002, and 2003 and noting that none of these acts were ever passed and signed into law).

87. MHPAEA, 29 U.S.C.A. § 1185(a) (West, WestlawNext current through P.L. 113-180).

88. See generally ACA, Pub L. No. 111-148, 124 Stat.119 (2010) (codified as amended in scattered sections of U.S.C.).

89. Barry et al., *supra* note 9, at 404.

90. MHPAEA, 29 U.S.C.A. § 1185(a); See also U.S. Dep’t of Labor, *Mental Health Parity Act and Addiction Equity of 2008 Fact Sheet (MHPAEA)* (Jan. 29, 2010), <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

91. HILDA SOLIS, U.S. DEP’T OF LABOR, REPORT TO CONGRESS: COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 4 (2012), available at <http://www.dol.gov/ebsa/pdf/mhpaeareporttocongress2012.pdf> (citing ERISA § 712; PHSA § 2726; and IRS Code § 9812).

92. *Id.* at 7.

93. See *Mental Health Parity and Addiction Equity Act of 2008 Fact Sheet*, *supra* note 90, at 1.

94. See, e.g., Barry et al., *supra* note 9, at 406–07.

pant upon request.<sup>95</sup>

Federal implementation and enforcement of the MHPAEA is handled by three agencies—the HHS, the Department of Treasury (“DOT”), and the Department of Labor (“DOL”).<sup>96</sup> Together, these departments work to promote broad-based compliance assistance efforts and investigate MHPAEA complaints.<sup>97</sup> The Departments receive complaints from group health plan participants and beneficiaries, enrollees in individual market health coverage, providers, and other stakeholders, and then work with these individuals and the regulated community to correct violations.<sup>98</sup>

Ongoing enforcement of the MHPAEA falls to different authorities depending on the type of insurance plan at issue.<sup>99</sup> State authorities, typically insurance commissioners, are responsible for enforcing the parity law’s mandate in the large group market, and overseeing individual and employer-funded plans with fewer than fifty-one insured employees.<sup>100</sup> Federal authorities also have a role, as the DOL and the Internal Revenue Service (“IRS”) are responsible for enforcement of the parity law over private sector employment-based plans subject to ERISA, while HHS is responsible for self-funded non-Federal governmental plans.<sup>101</sup> Additionally, HHS may intervene to enforce rights in the individual or group markets if it determines a state has failed to “substantially enforce” the MHPAEA.<sup>102</sup>

In November 2013, the DOT, DOL, and HHS issued a final rule fully implementing the MHPAEA.<sup>103</sup> The regulation directly addressed enforcement, declaring that state insurance commissioners will be the main en-

95. SOLIS, *supra* note 91, at 8.

96. SOLIS, *supra* note 91 at 4, Enforcement, 6-7. (explaining efforts are allocated between HHS, DOT, and DOL because the MHPAEA amended ERISA, PHSA, and the IRS code with parallel provisions. Accordingly, it is considered a “tri-agency rule,” and the Departments share enforcement efforts based on long-standing precedent.); *See also* Alden Bianchi, *Final Regulations Issued under the Mental Health Parity and Addiction Equity Act of 2008*, MINTZ LEVIN (Dec. 13, 2013), <http://www.mintz.com/newsletter/2013/Advisories/3574-1213-NAT-ELB/index.html>.

97. SOLIS, *supra* note 91, at 22.

98. Emp. Benefits Sec. Admin., *FAQs About Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation*, U.S. DEP’T OF LABOR (Nov. 8, 2013), <http://www.dol.gov/ebsa/faqs/faq-aca17.html>.

99. Substance Abuse & Mental Health Servs. Admin., *Mental Health Parity and Addiction Equity Act (MHPAEA)*, <http://beta.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act> (last updated Sept. 24, 2014).

100. *Id.* (state insurance commissioners are also responsible for monitoring fully-insured large group plans).

101. *Id.*

102. *Id.*

103. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule, 78 Fed. Reg. 68240,68240 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146 and 147), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf> [hereinafter Final Rules].

forcement authority and primary means of enforcing the MHPAEA.<sup>104</sup> In doing so, the Obama Administration deferred to states as the regulators of insurance.<sup>105</sup> The regulation became effective in January 2014 and applies to plan years beginning on or after July 1, 2014.<sup>106</sup>

The final rule includes a number of provisions detailing permissible financial requirements and treatment limitations under the MHPAEA<sup>107</sup> and provides additional consumer protections.<sup>108</sup> Regarding enforcement, the Centers for Medicare and Medicaid Services (“CMS”) stated that it believed most states had the authority to enforce the parity law and were already acting appropriately.<sup>109</sup> In states lacking the authority to enforce the law, CMS stated it would either directly enforce the MHPAEA or collaborate with state insurance departments to ensure compliance.<sup>110</sup>

### C. Enforcement under the ACA

President Barack Obama signed the ACA into law on March 23, 2010.<sup>111</sup>

104. SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., *supra* note 99 (“State insurance commissioners oversee individual and employer-funded plans of less than 51 insured employees, as well as fully-insured large group plans.”); *id.*

105. *See supra* Part 0 for a discussion of health insurance law with respect to federalism.

106. THE CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 14.

107. *Id.*

108. *See* Press Release, U.S. Dep’t of Health & Servs., Administration Issues Final Mental Health and Substance Use Disorder Parity Rule (Nov. 8, 2013), <http://www.hhs.gov/news/press/2013pres/11/20131108b.html> (explaining that these additional consumer protections include ensuring parity applies to intermediate levels of care in certain treatment settings; clarifying the scope of transparency required by health plans; clarifying the standards to which parity applies; and eliminating loopholes in the original Act).

109. Final Rules, 78 Fed. Reg. 68240, 68252 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146 and 147), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>.

110. *Id.* On the DOL website, agency enforcement efforts were further detailed:

[DOL, HHS, & IRS] are working with plans, issuers, and their service providers to help them understand and come into compliance with MHPAEA and to ensure that individuals receive the benefits they are entitled to under the law. The Departments also coordinate with State regulators both individually and through the National Association of Insurance Commissioners to ensure compliance and issue guidance to address frequently asked questions from stakeholders. Compliance assistance is a high priority and the Departments’ approach to implementation is marked by an emphasis on assisting plans and issuers that are working diligently and in good faith to comply with the requirements of the law.

EMP. BENEFITS SEC. ADMIN., *FAQs About Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation*, U.S. DEP’T OF LABOR (Nov. 8, 2013), <http://www.dol.gov/ebsa/faqs/faq-aca17.html>.

111. Patient Protection and Affordable Care Act (PPACA), Pub L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

The ACA attempts to overhaul certain aspects of the American health care system with the stated goals of controlling costs, expanding insurance coverage, and improving the overall quality of care in the United States.<sup>112</sup> The ACA requires most American citizens and legal residents to have health insurance and is expected to result in thirty-eight million uninsured Americans obtaining insurance by 2018.<sup>113</sup> The law creates state- or federally-based marketplaces from which individuals and small businesses can purchase coverage.<sup>114</sup> To encourage more Americans to become insured and more employers to provide employee health coverage, the ACA imposes tax penalties on individuals and some employers who do not comply with the ACA's provisions.<sup>115</sup> The law offers premium credits and cost-sharing subsidies to eligible individuals and families who meet certain income thresholds and expands certain public programs such as Medicaid.<sup>116</sup>

The ACA mandates coverage of MH and SU disorder benefits for a number of new types of insurance plans.<sup>117</sup> Specifically, Section 1302(b)(1) requires that issuers offering coverage through the individual or small group markets must cover EHBs including MH and SU disorder treatment.<sup>118</sup> These benefits are enabled through Section 1301 of the law, which dictates that the QHPs offered on the new ACA Exchanges include EHBs.<sup>119</sup>

Federal law for the first time is mandating mental health and substance use disorder benefits in certain plan settings; that is, the exchange-offered qualified health plan, the non-exchange individual health plan, the non-exchange small group health plan, the Medicaid benchmark plan, the benchmark-equivalent plan, and the Medicaid state plan settings.<sup>120</sup>

Although HHS could have defined EHBs through regulation, the Obama

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112. *Summary of the Affordable Care Act*, HENRY J. KAISER FAMILY FOUND., 1 (Apr. 23, 2013), <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf> [hereinafter *Summary of ACA*].

113. *Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act*, CONG. BUDGET OFFICE (CBO) 3 (Apr. 2014), [http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA\\_Estimates.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf) (More specifically, 25 million are expected to obtain coverage through the Exchanges and 13 million through the expansion of Medicaid and CHIP).

114. PPACA, Pub. L. No. 111-148, § 1304, 124 Stat. 171-72 (2010) (codified at 42 U.S.C. § 18024); *see also Summary of ACA*, *supra* note 112.

115. *Summary of ACA*, *supra* note 112, at 1.

116. *Id.* at 1-2.

117. *See Tovino, All Illnesses*, *supra* note 19, at 40-42 (“[M]any health insurance plans that were previously exempt from [providing mental health benefits at parity] are now are prohibited from offering inferior mental health insurance benefits.”).

118. PPACA, Pub. L. No. 111-148, §1302(b)(1), 124 Stat. 163-64 (codified at 42 U.S.C. § 18022).

119. *Id.* at §1301 (codified at 42 U.S.C. § 18021).

120. *Tovino, All Illnesses*, *supra* note 117, at 42.



Administration chose not to standardize the definitions of EHBs, instead allowing each state to create its own benchmark plan model.<sup>121</sup> Benchmark plans, serving as reference plans, reflect the scope of services and limitations offered by typical employer plans in each state.<sup>122</sup> If states did not select a benchmark plan, HHS chose one for them.<sup>123</sup> In adopting this approach, the Administration granted states and payers broad authority to establish EHB standards, including MH.<sup>124</sup> Accordingly, states submitted benchmark plans to Consumer Information and Insurance Oversight in 2012, detailing benefit inclusions, exclusions, and other limitations.<sup>125</sup>

Under the ACA, both federal and state authorities are expected to monitor certified QHPs, its EHBs, and enforce any ACA provisions or related regulations a plan fails to satisfy. The ACA defines a QHP as:

The term ‘qualified health plan’ means a health plan that—(A) has in effect a certification . . . that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered; (B) provides the essential health benefits package described in section 1302(a); and (C) is offered by a health insurance issuer that—(i) is licensed and in good standing to offer health insurance coverage . . . (ii) agrees to offer at least one qualified health plan in the [silver and gold levels] in each such Exchange; (iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and (iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange

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121. *Essential Health Benefits Bulletin*, CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 8 (Dec. 2011), [http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential\\_health\\_benefits\\_bulletin.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf). The Administration elected not to define EHBs despite urging from a number of advocates, including the Institute of Medicine. *Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans*, INST. OF MED. 8-2 (Cheryl Ulmer et al. eds., 2011), <http://www.sph.umich.edu/vbidarchive/healthreform/pdfs/IOM%20EHB%20Balancing%20Coverage%20and%20Costs.pdf>.

122. Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.L. & MED. 471, 494 (2012) [hereinafter *A Proposal*].

123. *Id.* (HHS based its choice on the “largest plan by enrollment in the largest product in the state’s small group market.”).

124. *Id.*

125. *See Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html> (last visited Nov. 11, 2014); *see infra* Appendix A for a review of the limitations and exclusions each state placed on their mental health and substance use disorder benefits in their benchmark plans.

may establish.<sup>126</sup>

Thus, each year, the Marketplaces will offer QHPs for each state that provides EHBs including MH and SU disorders. Thus, an initial step in enforcing the MH and SU benefits required under the ACA is ensuring that QHPs offered through marketplaces offer complete and comprehensive coverage consistent with EHB requirements.

The type of marketplace in effect in each state dictates which entity bears the responsibility of certifying and monitoring QHPs. One option is for states to offer QHPs through the establishment and operation of their own State-based Exchange (“SBE”). In SBEs, state authorities are generally responsible for monitoring QHPs and enforcing ACA compliance.<sup>127</sup> This complies with Title XXVII of the PHSA, which provides that states have primary enforcement authority in local health insurance markets.<sup>128</sup> However, even with SBEs, the federal government maintains compliance authority. Section 1331(f) of the ACA calls for “Secretarial Oversight,” which requires HHS to review state programs for compliance with the ACA, including verifying that participating plans meet the requirements for program certification, as well as the quality and performance standards under the Act.<sup>129</sup> Federal regulations go further, requiring states to: keep an accurate accounting of Exchange receipts and expenditures; monitor and report to HHS on exchange-related activities; collect and report to HHS performance monitoring data; and at least annually, provide HHS with financial statements, eligibility and enrollment reports, and performance monitoring data.<sup>130</sup>

In contrast, the federal government will establish and operate Federally-facilitated Exchanges (“FFE”) for states that do not establish their own SBE.<sup>131</sup> CMS is responsible for nearly all FFE functions under this model,

126. PPACA, Pub. L. No. 111-148, §1301, 124 Stat. 162 (codified at 42 U.S.C. § 18021) (emphasis added).

127. See Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs. to Issuers in the Federally-facilitated Marketplaces 6 (Mar. 14, 2014), <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf> (noting that SBEs “will conduct their own reviews for QHP-specific standards”).

128. Public Health Services Act, 42 U.S.C.A. § 300gg-22 (West, Westlaw through P.L. 113-174 approved Sept. 26, 2014); see also *Compliance*, CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 1, 2014), <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html> (“[S]tates are to exercise primary enforcement authority over health insurance issuers in the group and individual markets to ensure compliance with health insurance market reforms.”).

129. PPACA, Pub. L. No. 111-148, § 1332(f), 124 Stat. 203 (codified at 42 U.S.C. § 18051).

130. 45 C.F.R. § 155.1200 (2013).

131. 42 U.S.C.A. § 18041 (West, Westlaw through P.L. 113-174 approved Sept. 26, 2014). States that elect not to establish an SBE, but still want a role in the operation of the

including “certifying, recertifying, and decertifying QHPs,” as well as determining individual eligibility for enrollment, and other related tasks.<sup>132</sup> CMS has provided detailed guidance on its QHP application, review, and certification process for coverage providers wishing to offer plans through FFEs in 2015.<sup>133</sup> After certification, issuers may be subject to HHS compliance reviews to ensure ongoing compliance with Exchange standards.<sup>134</sup> However, CMS will not ensure QHP compliance with state law and expects states to review potential QHPs for compliance with ACA market-wide standards, including the important EHBs.<sup>135</sup>

#### IV. MHPAEA ENFORCEMENT TO DATE

Although the MHPAEA was passed two years before the ACA, implementation and enforcement of its provisions have been slow, and to a large extent, overshadowed by the breadth of the ACA’s changes. This is not surprising since the MHPAEA is considerably lesser known.<sup>136</sup> Even Patrick J. Kennedy, one of the congressional leaders who pushed the MHPAEA through Congress, acknowledged that the fight for parity has been somewhat “pushed aside in the larger healthcare battle.”<sup>137</sup> Moreover, the final rule implementing the MHPAEA was not issued until late 2013. This section describes the limited MHPAEA enforcement that has taken place to date.

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health insurance Exchange in their state may help manage a Partnership-based Exchange (PBE). See Ctr. for Consumer Info. and Ins. Oversight, *Affordable Insurance Exchanges Guidance: Guidance on the State Partnership Exchange*, CTRS. FOR MEDICARE & MEDICAID SERVS. 3 (Jan. 3, 2013), <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf>. Under this hybrid model, states assume primary responsibility for carrying out certain Exchange functions of the FFE in their state, including plan management, QHP certification, consumer assistance, and public outreach. *Id.* at 3-4. A PBE “enables a state to be actively involved in Exchange operations, continue to play a primary role in interacting with issuers and consumers in the state, and make recommendations as to how local market factors should inform the implementation of Exchange standards.” *Id.* at 3. HHS expects that states operating PBEs will eventually operate their own SBE, independent of federal authority. See *id.*

132. HHS Releases *Guidance on Exchanges, Including Draft Exchange Blueprint and Rules for Federally Facilitated Exchanges and SHOPS*, CORNERSTONE GROUP (June 4, 2012), [http://www.teamcornerstone.com/reform\\_bulletins/REFORMBulletin32.pdf](http://www.teamcornerstone.com/reform_bulletins/REFORMBulletin32.pdf).

133. See *id.*

134. 45 C.F.R. § 156.715(a) (2013).

135. Letter from CCIIO, Ctrs. for Medicare & Medicaid Servs. to Issuers in the Federally-facilitated Marketplace, *supra* note 127, at 9.

136. See, e.g., *Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act*, MILLIMAN, INC., P’SHIP FOR WORKPLACE MENTAL HEALTH 3 (Dec. 2012), <http://www.workplacentalhealth.org/erguide> (finding that “many employers have limited knowledge of the details of MHPAEA requirements”).

137. Patrick J. Kennedy, Former U.S. Congressman, Discussion at the University of Pennsylvania Law School: How the Parity Law Will Transform Substance Abuse and Mental Healthcare (June 3, 2014), available at <http://www.youtube.com/watch?v=bkfyK1ojRbw>.

A. *Obstacles to Enforcement*

The difficulties in enforcing the MHPAEA begin with the language of the law itself. Although the MHPAEA provides authority to issue regulations, it does not provide any actual framework for enforcement.<sup>138</sup> The Act includes a number of extremely detailed and complex provisions, which have made complying with the law difficult for many providers.<sup>139</sup> Even the federal departments responsible for implementing and enforcing the law did not comprehend the MHPAEA's complexity until after issuing an interim final rule.<sup>140</sup> Making matters worse, no public record of enforcement currently exists.<sup>141</sup> Most troubling, the DOL "requires only 'good faith' compliance for any potentially 'gray areas' in the law and regulations," an approach that may only perpetuate the inadequate and inefficient status quo.<sup>142</sup>

Without a proper statutory framework or sufficient regulatory guidance, many mental health advocates have become frustrated with the federal government's enforcement efforts.<sup>143</sup> The American Psychiatric Association ("APA"), for example, argues that "by directing state insurance departments to enforce the parity law, the federal government [has ceded] enforcement authority to groups that lack the funding, the clout, and the will to do a good job."<sup>144</sup> This is evidenced by the fact that as of 2011, several states declared that they did not have the authority to enforce the federal MHPAEA.<sup>145</sup> This is likely the most significant factor behind the ineffective and inconsistent parity law enforcement seen to date.<sup>146</sup> Parity advocates further insist that

138. Weber, *supra* note 6, at 223.

139. MILLIMAN, INC., *supra* note 136, at 1; *see, e.g.*, 29 U.S.C.A. § 1185a(a)(3)(a) (West, WestlawNext through P.L. 113-163); 29 C.F.R. § 2590.712(c)(2) (2014).

140. *See* SOLIS, *supra* note 91, at 27 (noting that after issuing the interim final rule implementing the parity law, "the Departments realized that the complexity of the law and regulations [gave] rise to many highly technical issues and questions").

141. Weber, *supra* note 6, at 230.

142. *Id.*

143. Alison Knopf, *APA: Connecticut Regulators' Deal with Anthem/WellPoint Misses Parity Mark*, 33 BEHAVIORAL HEALTHCARE 10, 10-11 (May-June 2013), available at <http://digimags.vendomegrp.com/html/BH-May-June-2013/#/12/> (discussing how the APA hopes that the federal government will interpret the regulations in the advent of a Connecticut lawsuit); *see, e.g.*, Weber, *supra* note 6, at 230 (noting that around 160 complaints have been filed through 2011 and no public record of enforcement exists).

144. Knopf, *supra* note 143, at 11.

145. *See* Letter from Am. Psychiatric Ass'n to Ctrs. for Medicare & Medicaid Servs. 3 (Dec. 19, 2012), available at <http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/APA%20on%20the%20Issues/Regulatory/12-19-2012-Proposed-Rule-on-Standards-Related-to-Essential-Health-Benefits.pdf> ("[W]e continue to hear from states where alleged MHPAEA violations have occurred who state they lack authority to enforce MHPAEA.").

146. *See* Laura Goodman, *Mental Health Parity: Advocacy is Increasing State Enforcement*, CMTY. CATALYST (June 2013), [http://www.communitycatalyst.org/docstore/publications/mh-parity-state-enforcement\\_062013.pdf](http://www.communitycatalyst.org/docstore/publications/mh-parity-state-enforcement_062013.pdf) ("While several reasons contrib-

the federal government's "muted response" to enforcement undermines the industry's imperative and ability to ensure providers properly comply with the law.<sup>147</sup>

Prior to November 2013, much of the criticism surrounding enforcement of the MHPAEA involved the lack of federal guidance in the form of a final rule.<sup>148</sup> For firms and providers charged with restructuring their plans and benefits to comply with the law, the lack of final guidance posed a significant challenge.<sup>149</sup> At field hearings for the parity law in 2013, many witnesses complained that their health plans continued to impede access to equitable treatment, attributing this difficulty in part to the lack of a final regulation.<sup>150</sup> Former Congressman Jim Ramstad, one of the parity law's chief proponents, noted shortly after the law's enactment: "It's clear that congressional intent is not being followed by the health plans, and that patients are being denied access to treatment. The regulators need to issue further regulatory guidance and enforce the regulations."<sup>151</sup>

In response to these and other comments, the preamble to the final rule noted there was confusion and concern about the Departments' ability to ensure compliance with the MHPAEA's requirements.<sup>152</sup> Our review of enforcement actions to date confirms, at a minimum, the Departments' concession.

### B. Enforcement Efforts to Date

There have been efforts to implement and enforce the parity law since the MHPAEA's inception in 2008, though most are the result of private enforcement. As of 2011, 160 parity complaints had been filed with the DOL.<sup>153</sup> Additionally, some state legislatures took steps to pass laws im-

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ute to [the lack of parity law enforcement], one of the most significant is states' hesitance-or even refusal-to do their share to enforce the federal parity law.").

147. Weber, *supra* note 6, at 230.

148. See, e.g., REPORT OF THE 2012-2013 PARITY FIELD HEARINGS, PATRIOTS FOR PARITY 10 (2013), available at <http://parityispersonal.org/sites/default/files/hearing%20report.pdf> (quoting the testimony of a Maryland doctor who said: "I am frustrated and even embarrassed that such a powerful law-one that places the health of our brains on the same level of importance as the health of our heart, our kidneys, our skin-still lacks the final regulations to add teeth to its requirements four years after being signed into law.").

149. Barry et al., *supra* note 9, at 423.

150. PATRIOTS FOR PARITY, *supra* note 148, at 10.

151. *Legal Action to Enforce Parity Contemplated, Ramstad tells ADAW*, ALCOHOLISM & DRUG ABUSE WKLY. 4, 4 (May 30, 2011).

152. Final Rules, 78 Fed. Reg. 68240, 68252 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146 & 147), available at <http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>.

153. Weber, *supra* note 6, at 230. Ellen Weber obtained this data from phone interviews with Carol McDaid, the co-chair of the Parity Implementation Coalition. See *id.* at n.225.

plementing the federal parity law in their own states.<sup>154</sup> However, to date there is no record, database, or information clearinghouse describing the nature and resolution of enforcement actions throughout the country.<sup>155</sup>

A major parity battle is currently being fought in Connecticut, where advocates have urged the Connecticut Insurance Department to more strictly enforce the MHPAEA and other insurance parity laws.<sup>156</sup> In April 2013, the APA filed a federal lawsuit against Anthem Health Plans and its parent company Wellpoint, Inc., claiming the companies violated MHPAEA by discriminating against mental health care patients.<sup>157</sup> The complaint alleges that Anthem has manipulated its billing codes<sup>158</sup> such that its reimbursement rates and billing structure violate the parity law by imposing greater burdens and expenses on mental health patients than those seeking non-mental health services.<sup>159</sup> In September 2013, the APA filed an amended complaint.<sup>160</sup> Although the APA waited months to see if the Connecticut Insurance Department or Anthem itself would correct the alleged parity violations, the APA found that neither the insurance department nor the provider took any steps to correct the problem.<sup>161</sup>

Similarly, the New York State Psychiatric Association filed a federal class-action lawsuit against United Health Group in March 2013.<sup>162</sup> The suit alleges United applied prior authorization policies exclusively to MH/SU services and imposed different financial requirements for mental health benefits than medical/surgical benefits.<sup>163</sup> The State Psychiatric Association

154. *E.g.*, MASS. GEN. LAWS ANN. ch. 26, § 8K (West, Westlaw through Ch. 306 of the 2014 2nd Annual Sess.); MINN. STAT. ANN. § 62Q.47(d) (West, Westlaw through the end of the 2014 Regular Sess.); NEV. REV. STAT. ANN. § 687B.404 (West, Westlaw through end of 28th Special Sess. (2014)).

155. Weber, *supra* note 6, at 230.

156. Goodman, *supra* note 146, at 1.

157. Press Release, Am. Psychiatric Ass'n, Am. Psychiatric Ass'n and Others Seek Court's Intervention in Compelling Anthem and Wellpoint to End Alleged Discrimination Against Mental Health Patients (Apr. 11, 2013) <http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Press%20Releases/2013%20Releases/13-21-APA-files-suit-against-Anthem.pdf> [hereinafter Psychiatric Ass'n and Others].

158. See Knopf, *supra* note 143, at 11 (noting that the billing code manipulation required patients seeking mental health services to pay an inconvenient double co-pay).

159. Complaint and Request for Jury Trial at 34, Am. Psychiatric Ass'n v. Anthem Health Plans, No. 3:13-CV-00494 (D. Conn. Apr. 10, 2013); see Goodman, *supra* note 146.

160. Press Release, Am. Psychiatric Ass'n, Psychiatric Ass'n and Others, *supra* note 157.

161. Press Release, Am. Psychiatric Ass'n, APA Files Amended Complaint Against Anthem Health Plans (Sept. 2013), <http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Press%20Releases/2013%20Releases/13-60-Anthem-Amended-Complaint.pdf>.

162. Complaint and Demand for Jury Trial at 1, N.Y. State Psychiatric Ass'n, Inc. v. United Health Grp., (S.D.N.Y. Mar. 11, 2013) (No. 1:13-CV-1599) 2013 WL 870320 (detailing United's violations of the federal parity law).

163. Goodman, *supra* note 146, at 2.

asserts United is preventing critical access to mental health services and contends the company is using “sham practices” to circumvent proper claims processing and rules of reimbursement.<sup>164</sup>

In April 2013, a district court in Vermont issued the first federal ruling interpreting the parity law.<sup>165</sup> In that case, an insurance plan utilized a policy that called for more stringent reviews of MH benefits than those imposed for medical benefits.<sup>166</sup> The health plan argued this was permissible because the practice fell within “recognized clinically appropriate standards of care.”<sup>167</sup> The plan further argued it was up to the plaintiff to show that the provider was operating outside the appropriate standard of care.<sup>168</sup> The Vermont court ruled for the plaintiff, holding that the insurance plan has the burden of establishing clinically appropriate standards of care to justify treating MH and SU claims differently than medical/surgical claims.<sup>169</sup>

One of the most high-profile examples of state enforcement of the MHPAEA occurred in California.<sup>170</sup> The California Department of Managed Health Care (“DMHC”) began an investigation into Kaiser Permanente (“Kaiser”) in 2012, finding Kaiser denied health plan members critical information about their potential MH and SU ‘disorder benefits.’<sup>171</sup> The primary allegation was that Kaiser provided complicated and misleading written descriptions of its mental health benefits to discourage enrollees from using them.<sup>172</sup> Not only did DMHC cite Kaiser for multiple violations of mental health laws, but it also issued Kaiser a cease and desist order coupled with a four million dollar fine.<sup>173</sup>

These efforts are laudable and represent both judicial and state authority to scrutinize MH parity. However, given the complexity of joint federal-state insurance regulation and the lack of standardization as far as what mental health benefits should include, this piecemeal state enforcement is

164. Complaint and Demand for Jury Trial, *supra* note 162 at 3.

165. Entry Order, *C.M. v. Fletcher Allen Health Care, Inc.*, No. 5:12-CV-108, 2013 WL 4453754 (D. Vt. April 30, 2013).

166. *Id.* at 7.

167. *Id.* at 6.

168. *Id.*

169. *Id.* at 9. The court found that it would not make sense to place the burden of proof on the plaintiffs: “Especially at the pleading stage, patients are unlikely to be aware of the potential range of ‘recognized clinically appropriate standards of care’ which may give rise to a difference in how mental health and medical services are treated and thus they would be left to speculate as to the clinical reasons for a particular disparity. Nothing in the Parity Act supports a conclusion that the burden of proof is allocated in this manner.” *Id.* at 6.

170. Goodman, *supra* note 146, at 1.

171. *Id.*

172. Cynthia H. Craft, *Kaiser mental health care lacking, state says; HMO hit with \$4 million fine*, THE SACRAMENTO BEE (June 26, 2013), available at <http://www.sacbee.com/news/local/health-and-medicine/article2577923.html>.

173. *Id.*

likely to be ineffective and costly, and will lead to inconsistent and fragmented results.<sup>174</sup> Many advocates have complained that the lack of proper federal enforcement jeopardizes the very existence of the parity law itself.<sup>175</sup>

#### V. A NEW APPROACH: ENFORCING MHPAEA THROUGH ACA'S EHB MANDATE

Current MHPAEA enforcement efforts returned mixed results at best.<sup>176</sup> A glaring weakness of the law is its failure to require providers to cover mental health services or offer any definition of mental health coverage standards.<sup>177</sup> This deficiency is not present in plans offered through marketplaces because QHPs must cover mental health benefits under the ACA.<sup>178</sup> Accordingly, all QHPs must also comply with the MHPAEA's parity mandate.<sup>179</sup> The result of this is that the ACA and MHPAEA interact to convert the MHPAEA's weak mandate into an actual, enforceable mandate for most insurance plans.<sup>180</sup> Given the potential impact of this new coverage-parity mandate on Americans struggling with MH/SU illnesses, the question of

174. See *supra* Part III.B. and accompanying text for information about the MHPAEA's complicated statutory framework and implementing regulations.

175. See Weber, *supra* note 6, at 232.

176. See *supra* Part IV.B. for a discussion of the difficulties of MHPAEA enforcement and efforts so far.

177. Kessler, *supra* note 19, at 153-54.

178. PPACA, Pub. L. No. 111-148 § 1311(j), 124 Stat. 181 (codified at 42 U.S.C. § 18031); see also Tovino, *supra* note 19, at 40 ("The dramatic effect of this provision is to expand application of [the MHPAEA] from just large group health plans to all qualified health plans offered on one of the new ACA-created state or regional health insurance exchanges."). The MHPAEA's parity mandate is also extended to: non-exchange individual health plans, non-exchange small group health plans, Medicaid benchmark plans, benchmark equivalent plan, and the Medicaid state plan. See *id.* at 40, 48.

179. See, e.g., Amanda K. Sarata, *Mental Health Parity and the Patient Protection and Affordable Care Act*, CONG. RESEARCH SERV. 4 (Dec. 28, 2011), <http://www.ncsl.org/documents/health/MHparity&mandates.pdf> (noting that "the ACA expands the reach of federal mental health parity law to . . . qualified health plans (QHPs), as established by the ACA"). The National Association of Insurance Commissioners also recognized the new and dramatic effect of the ACA and MHPAEA's interaction:

Section 1311(j) of the ACA states 'Section 2726 of the Public Health Service Act (PHSA) shall apply to QHPs in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.' In turn, Section 2726 of the PHSA applies to a 'group health plan or a health insurance issuer offering group or individual health insurance coverage.' Therefore, the requirements of the MHPAEA must be applied to all plans of health insurance coverage whether issued inside and outside of the Exchange, to an individual or through an employer group.

NAT'L ASS'N OF INS. COMM'RS, *supra* note 13, at 10.

180. Kessler, *supra* note 19, at 159.



whom or what will monitor and enforce this mandate is of significant importance if true coverage parity is ever to be achieved.

Read together, the ACA and MHPAEA extend health insurance coverage to more people, expand the scope of that coverage to include MH/SU benefits, and improve the coverage provided through these benefits.<sup>181</sup> However, although states may be actively seeking to comply with the ACA, coverage deficiencies still exist, even in qualified health plans that are certified for sale on the new Exchanges.<sup>182</sup> This is due, at least in part, to the Administration's decision to allow states to create their own definitions of EHBs.<sup>183</sup>

In its final regulation implementing the MHPAEA, HHS declared that state insurance commissioners will be the main enforcement authority and "primary means" of enforcing the law.<sup>184</sup> Similarly, HHS also expects states to review potential QHPs for compliance with ACA EHBs, including MH and SU disorder services, on all types of ACA Exchanges.<sup>185</sup> These decisions will not result in expanded MH coverage at parity.<sup>186</sup> Although HHS' enforcement decisions are consistent with traditional federalist principles,<sup>187</sup> they are at odds with the goal of properly and consistently enforcing the MH parity mandate, as well as the views of parity advocates across the country.<sup>188</sup>

But, there is another approach. A logical starting point for enforcement

181. *See id.*

182. *See* Grace et al., *supra* note 17 at 2143 (concluding that the "state-by-state benchmark plan approach" has resulted in "a state-by-state patchwork of coverage for children and adolescents that has significant exclusions, particularly for children with developmental disabilities and other special health care needs. These findings demonstrate a missed opportunity by HHS to strengthen pediatric benefits under the ACA's essential health benefits standard.").

183. *Id.* at 1, 4 (suggesting a "solution is for the Secretary to mandate a benchmark habilitation benefit for states to follow, essentially creating a national standard of basic . . . benefits"); *see also infra* Appendix A (finding broad variability in state-based benchmark plans as to how states define, limit, and exclude mental health and substance abuse EHBs).

184. Valerie A. Canady, *Final Parity Rule Opens Door to Increased Activity on Enforcement Front*, MENTAL HEALTH WKLY. (Nov. 14, 2013), <http://www.mentalhealthweeklynews.com/m-article-detail/final-parity-rule-opens-door-to-increased-activity-on-enforcement-front.aspx>.

185. *See* SAMHSA, *supra* note 99 for details about QHP compliance in FFEs.

186. *See supra* Part IV.B. for MHPAEA enforcement challenges.

187. *See supra* Part II.A. for a discussion of the state role as the primary regulator of insurance.

188. *See, e.g.,* PATRIOTS FOR PARITY, *supra* note 148, at 19 ("The federal government's enforcement actions directly influence the level of voluntary compliance by employers and the effectiveness of enforcement efforts by those on the ground. . . . [A]n investment of resources at the federal level to monitor compliance with parity [is needed]. This should include a way for patients to register complaints about parity violations that will be addressed promptly and in a meaningful way."); Knopf, *supra* note 143, at 10–11; Weber, *supra* note 6, at 230.

efforts is the ACA's qualified health plans and MH/SU EHBs requirements. In order to sell QHPs on the new health insurance Exchanges, providers must cover MH and SU disorder benefits as part of the EHB package mandated by the healthcare law.<sup>189</sup> As a first step, HHS has the authority to revisit benchmark plans and provide a specific, standardized definition of the MH and SU EHBs.<sup>190</sup> Such an action is permissible under the ACA and has been advocated for by other legal scholars.<sup>191</sup> HHS is already charged with performing nearly all FFE functions, including "certifying, recertifying, and decertifying QHPs."<sup>192</sup> In Partnership and SBEs, ACA section 1331(f) permits "Secretarial Oversight," requiring HHS to verify that plans participating in state marketplaces meet the requirements for program certification, as well as the quality and performance standards under the Act.<sup>193</sup> There is no reason HHS cannot readily enforce the MHPAEA through the Exchanges.

Enforcement of the parity law should begin with HHS and then proceed concurrently with both federal and state involvement. Restrictions on federal involvement in the enforcement of national policy can lead to the uneven state implementation of national priorities and the existence of unfunded mandates.<sup>194</sup> This is particularly true when state insurance departments are involved because many of them lack sufficient staff and funding to properly carry out basic regulatory functions.<sup>195</sup> Additionally, federal authorities can more consistently enforce the parity law's mandate, crafting a more coherent compliance policy than disjointed and fragmented state actors.<sup>196</sup> Federal enforcement can also lead to increased visibility, awareness, and greater deterrence.<sup>197</sup>

In our own review of all fifty state benchmark plans, included in Appendix A, we examined MH inpatient and outpatient benefits, as well as SU disorder inpatient and outpatient benefits. From state to state, we found broad variability in how plans defined and limited their benefits. States also placed a variety of different exclusions on these benefits, sometimes denying coverage for underlying conditions. As part of its initial enforcement

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189. PPACA, 42 U.S.C. §18022 (West, Westlaw through P.L. 113-174 approved Sept. 26, 2014).

190. 78 Fed. Reg. 12834, 12841 (Feb. 35, 2013) (to be codified at 45 C.F.R. pts. 147, 155, & 156) (describing HHS's plans to ensure EHB and benchmark plan compliance, along with its intention to revisit aspects of its policy for later benefit years).

191. See, e.g., *Tovino, A Proposal*, *supra* note 122, at 514 (proposing "that HHS consider adopting a comprehensive essential mental health and substance use disorder benefit").

192. See CORNERSTONE GROUP, *supra* note 132.

193. PPACA, Pub. L. No. 111-148, § 1332(f), 124 Stat. 203 (codified at 42 U.S.C. § 18051).

194. See *supra* Part IV.A. discussing enforcement of the MHPAEA.

195. Randall, *supra* note 47, at 699.

196. Rose, *supra* note 26, at 1361.

197. PATRIOTS FOR PARITY, *supra* note 148, at 17.

work, HHS could review these benefit differences—their exclusions and limitations—and identify a minimum coverage floor for all QHPs to serve as a starting point for MHPAEA enforcement. This alone could provide an unprecedented level of standardization for MH parity enforcement, whether implemented by federal or state government.

## VI. CONCLUSION

The ACA and MHPAEA work in tandem to require insurance plans provide MH and SU services of equal scope and quality to other medical/surgical benefits.<sup>198</sup> This mandate must be properly monitored and enforced to have any real impact on mental healthcare in the United States. The most effective way to enforce this mandate—at least in the immediate term—is at the federal level, particularly through the standardizing of what MH and SU benefits mean under health plans sold through the federal and state marketplaces

In the past, some regarded MH issues to be of lesser importance than physical health issues.<sup>199</sup> This opinion largely fell out of favor during the past two decades, given the federal government’s efforts to enact MH parity legislation.<sup>200</sup> Today, the need to properly enforce MH coverage parity is arguably greater than ever.<sup>201</sup> Repeated national tragedies and painful social

198. See *supra* Part V for further discussion about this new “coverage-parity mandate.”

199. See, e.g., Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 8 (2000) (noting that the passage of mental health parity law legislation indicates the American public’s interest and support for coverage parity); Kessler, *supra* note 19, at 149-50 (describing the dark history of mental illness in the United States and the stigmatization that remains even today).

200. See *supra* Part II for a full discussion of the most critical pieces of modern mental health parity law.

201. See, e.g., Victoria Veltri, *Findings and Recommendations: Access to Mental Health and Substance Use Services*, CONN. OFFICE OF THE HEALTHCARE ADVOCATE iv (2013) (discussing the 2012 mass shooting in an elementary school in Newtown, CT and how that tragedy brought the need for proper access to mental health care into “sharp relief”); see also Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 THE NEW ENG. J. OF MED. 13 (July 1, 2004) (finding that exposure to combat result in considerable risks of mental health problems, including post-traumatic stress disorder (PTSD), major depression, substance abuse, impairment in social functioning and in the ability to work). There is also a distressing prevalence of post-traumatic stress disorder and suicide plaguing American soldiers returning from combat operations in Afghanistan and Iraq, with as many as 22 veterans committing suicide each day. Jordan Carney, *How Can Government Battle a “Suicide Epidemic” Among War Veterans?*, NAT’L J. DAILY (Apr. 3, 2014), <http://www.nationaljournal.com/defense/how-can-government-battle-a-suicide-epidemic-among-veterans-20140403>; Amy Laskowski, *Aftermath of Marathon Bombings: Anxiety, Fear Persist for Some*, BU TODAY (Apr. 24, 2013), <http://www.bu.edu/today/2013/aftermath-of-marathon-bombings-anxiety-fear-persist-for-some/> (discussing the city of Boston’s mental health response to the Boston Marathon Bombing); Magdalene Perez, *After Aurora: Has mental health care improved?*, MSN NEWS (July 18, 2013),

issues, driven in part by improperly treated mental illnesses, brought the issue of MH to the public's attention—perhaps more than ever before.<sup>202</sup> The ACA and MHPAEA parity promise could potentially help millions with these diseases, finally “putting our brains on the same level” as the rest of our bodies.<sup>203</sup> However, this goal can only be accomplished if coverage-parity exists and is properly enforced by federal and state enforcement authorities working together.

#### APPENDIX A

In order to understand how to enforce the parity mandate through the ACA, one must first understand how QHPs, EHBs, and Exchanges operate and relate to one another under the ACA. The ACA requires the establishment of an Affordable Insurance Exchange in each state to begin operating on January 1, 2014.<sup>204</sup> States are free to set up and operate their own Exchanges, but are not required to do so.<sup>205</sup> Instead, a state may partner with the federal government to establish a Partnership Exchange, or if a state elects not to create its own marketplace, then the HHS will operate a FFE in that state.<sup>206</sup>

The healthcare marketplace will offer consumers and small business owners their choice of a number of QHPs.<sup>207</sup> In order for an insurance plan to qualify as a QHP, it must include coverage for a number of EHBs mandated by the ACA and standardized by each state's EHB-base benchmark plan.<sup>208</sup> These benchmark plans, and subsequently, any QHP, must provide

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<http://www.surreycounsellors.com/after-aurora-has-mental-health-care-improved/> (discussing the 2012 Aurora, Colorado theater shooting and its impact on mental health care reform).

202. Letter from A. Thomas McClellan, Founder and CEO, Treatment Research Inst. (June 3, 2014) (on file with author) (stating that “we are at a watershed moment in behavioral health. Public awareness about addiction and mental illness is growing, legislative advances have brought us ever close to parity and integrated care, and the research base is expanding so that we can better address the social and biological determinants of these disorders”).

203. PATRIOTS FOR PARITY, *supra* note 148, at 10.

204. PPACA, 42 U.S.C.A. § 18031 (West, Westlaw through P.L. 113-174 approved Sept. 26, 2014).

205. *Id.* at § 18041.

206. See *State Decisions for Creating Health Insurance Marketplaces*, KAISER FAM. FOUND (2014), <http://kff.org/health-reform/state-indicator/health-insurance-exchanges/> (stating that there currently are fourteen state-based marketplaces; seven partnership marketplaces; and twenty-seven federally facilitated marketplaces).

207. See 42 U.S.C.A. § 300gg-6 (West, Westlaw through P.L. 113-174 approved Sept. 26, 2014) (“A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.”).

208. See 45 C.F.R. § 156.20 (West, Westlaw through Nov. 4, 2014; 79 FR 68087); 45 C.F.R. §156.100 (West, Westlaw through Nov. 4, 2014; 79 FR 68087); 45 C.F.R. §156.110 (West, Westlaw through Nov. 4, 2014; 79 FR 68087). Benchmark plans define essential

the following benefits: hospitalization, outpatient hospital and clinical services (including emergency services), physician services, medical services, preventive services, prescription drugs, rehabilitation services, maternity care, baby and childcare for children twenty-one years and younger, early and periodic screening, diagnosis and treatment for children up to age twenty-one, and most importantly, mental health, behavioral health, and substance abuse disorder services.<sup>209</sup> If the selected benchmark package does not cover a required category, the state is required to supplement the package with benefits from another source.<sup>210</sup>

Although all state EHB-benchmark plans covered MH and SU benefits, the majority of states also placed treatment exclusions and limitations on their coverage. This is permissible under the ACA, but “[c]urrently, annual limits on the dollar value of EHBs are restricted and lifetime limits on the dollar value of EHBs are prohibited.”<sup>211</sup> The MHPAEA further requires that these limits and exclusions be no more restrictive than the financial requirements and treatment limitations placed on the medical/surgical benefits covered by the health plan.

Appendix A explores the limits and exclusions each state placed on its 2012 EHB-benchmark plans with an emphasis on mental/behavioral health and substance use disorder in- and out-patient benefits.

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health benefit coverage in each state, and also set the standard for qualified health plans sold in the health exchanges. *See* Grace et al., *supra* note 17 at manuscript 2136-37.

209. PPACA, 42 U.S.C. §18022 (West, Westlaw through P.L. 113-174 approved Sept. 26, 2014); *see also* 45 C.F.R. §156.110(b)(1) (West, Westlaw through Nov. 4, 2014; 79 FR 68087) (“A base-benchmark plan that does not include items or services within one or more of the categories described in paragraph (a) of this section must be supplemented . . .”).

210. NAT’L ASS’N OF INS. COMM’RS, *supra* note 13, at 9.

211. *Id.* at 10.

*A. Limits*

## 1. Quantitative Limits on Mental Health In-Patient Services

<b>Service</b>	<b>Mental/Behavioral Health In-Patient Services (MHIP)</b>	
<b>Limit</b>	<b># of States</b>	<b>States</b>
No limit	29	AK, AZ, CA, CO, CT, DC, GA, HI, ID, IL, KS, LA, ME, MD, MO, MT, NV, NH, NJ, NM, NC, ND, RI, SD, VT, VA, WA, WV, WI
1–14 days / yr	1	TX
14–31 days / yr	16	AL, DE, FL, IN, IA, KY, MI, MS, NE, NY, OH, OK, PA, TN, UT, WY
< 31 days / yr	2	MA, OR
Other	3	AR, MN, SC

Over half of the states did not place any limits on their mental health in-patient services (“MHIP”) service. Those that did typically restricted the availability of these services to a set number of days per year. These ranged from ten days per year (TX) to sixty days per year (MA). Thirteen states limited these services to thirty or thirty-one days per year. Three states limited these services using some other criteria, such as “7 days per benefit period” (SC) or “365 day max confinement” (MN). Many states combined the limits they placed on their MHIP services with the limits placed on the substance use disorder in-patient (“SUIP”) services, described in further detail below.

## 2. Quantitative Limits on Substance Use Disorder In-Patient Services

Service	Service Substance Use Disorder In-Patient Services (SUIP)	
Limit	Number of States	States
No limit	32	AK, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, KS, LA, ME, MD, MA, MI, MT, NV, NH, NJ, NM, NC, ND, OR, RI, SD, VT, VA, WA, WV, WI
1–14 days / yr	1	MS
14–31 days / yr	12	AL, IN, IA, KY, MO, NE, OH, OK, PA, TN, UT, WY
< 31 days / yr	2	AZ, NY
Other	4	AR, MN, SC, TX

Nearly two-thirds of all states placed no limit on their SUIP service. Typically, if a state did not limit MHIP, then it also did not limit SUIP; however, this was not always the case (AZ). Additionally, some states that did limit MHIP *did not* limit SUIP (DE, FL, MA, OR). Other states included multiple limits: ninety days per year *or* two treatments per year (AZ). Limits for SUIP ranged from seven days per year (MS) to ninety days per year (AZ). Some states did not limit the service to days per year, instead opting to limit SUIP services to “3 treatments per lifetime” (TX) or “7 days per benefit period” (SC). Sometimes the limits on SUIP services were shared with the limits placed on MHIP services.

## 3. Quantitative Limits on Mental/Behavioral Health Out-Patient Services

<b>Service</b>	<b>Mental/Behavioral Health Out-Patient Services (MHOP)</b>	
<b>Limit</b>	<b>Number of States</b>	<b>States</b>
No limit	32	AK, AZ, CA, CO, CT, DC, GA, HI, ID, IL, KS, LA, ME, MD, MN, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OR, RI, SD, VT, VA, WA, WV, WI
1–14 visits / yr	1	UT
14–31 visits / yr	15	AL, DE, FL, IN, KY, MA, MI, NY, OH, OK, PA, TN, TX, WY
< 31 visits / yr	2	IA, MS
Other	2	AR, SC

Unlike inpatient services, outpatient services were typically limited by visits per year, rather than days per year. This change did not affect the number of states offering this service without limitation, as once again nearly two-thirds of all states placed no limits on mental health outpatient (“MHOP”) services. Only one state limited the service to fewer than fourteen visits per year (OH with eight visits per year), being the most limited of the plans, while two states limited visits to fifty-two visits per year (IA, MS). States that did not limit their MH services by days or visits per year largely continued to do the same with SU services.



## 4. Quantitative Limits on Substance Use Disorder Out-Patient Services

<b>Service</b>	<b>Substance Use Disorder Out-Patient Services (SUOP)</b>	
<b>Limit</b>	<b>Number of States</b>	<b>States</b>
No limit	35	AK, AZ, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, KS, LA, ME, MD, MA, MI, MN, MT, NE, NV, NH, NJ, NM, NC, ND, OR, RI, SD, VT, VA, WA, WV, WI
1–14 visits / yr	1	UT
14–31 visits / yr	9	AL, IN, KY, MS, MO, OH, OK, TN, WY
< 31 visits / yr	3	IA, NY, PA,
Other	3	AR, SC, TX

In terms of quantifiable limits, substance use disorder out-patient (“SUOP”) services were the least limited of the four services considered above: thirty-five out of fifty-one states (including D.C.) did not place a limit on this service. Only one state (UT) placed a limit of fourteen visits or less per year. The actual limits ranged from eight visits per year (UT) to sixty visits per year (NY, PA). For some states, the limits on MHOP and SUOP services were combined, meaning a patient’s actual available visits are possibly lower than what the states list.

*B. Exclusions*

## 1. State Exclusions on MHIP/OP and SUIP/OP Benefits

<b>States with No Listed Exclusions by Benefit</b>		
<b>Benefit</b>	<b>Number of States</b>	<b>States</b>
MHIP	24	AL, AZ, AR, CA, CT, DE, DC, HI, ID, KS, MA, MI, MN, MT, NE, NV, NM, NY, OK, SC, SD, TX, WA, WI
MHOP	23	AL, AZ, AR, CA, CT, DE, DC, HI, KS, MA, MI, MN, NE, NV, NM, NY, OK, PA, SC, SD, TX, WA, WI
SUIP	22	AL, AZ, AR, CA, CT, DE, DC, KS, LA, MA, MI, MN, MT, NV, NM, NY, OK, SC, SD, TX, WA, WI
SUOP	23	AL, AZ, AR, CT, DE, DC, FL, GA, KS, LA, MA, MI, MN, NV, NM, NY, NC, OK, SC, SD, TX, WA, WI
<b>All</b>	<b>19</b>	<b>AL, AZ, AR, CT, DE, DC, KS, MA, MI, MN, NV, NM, NY, OK, SC, SD, TX, WA, WI</b>

The majority of states (thirty-two out of fifty-one) listed one or more exclusions for at least one of the four benefits. A little over one-third (nineteen out of fifty-one) states listed no exclusions for any of the benefits. Among the states that did include exclusions, many common trends were visible in the state-by-state benchmark plans. Many states excluded various types of counseling from their MHIP/MHOP benefits that could not be deemed “medically necessary.” These included:

- Special education services, educational testing and programs, or career counseling
- Martial, divorce, family, and sex counseling or therapy
- Social maladjustment treatment
- Religious and pastoral counseling

A few states took a broader approach, excluding any treatment deemed “medically unnecessary” from the benefit, rather than listing out the specific types of services. Many of these states extended these same exclusions to their SUIP/SUOP benefits as well.

Another common exclusion was residential treatment centers (“RTC”). Quite a few states are not willing to pay for individuals to go to rehab after initially treating their MH and SU problems. States that specifically excluded RTCs include: AK, IL, IN, IA, MO, NC, and others. On the other hand, at least one state specifically included residential treatment programs (VT).

Another recurring exclusion was court ordered therapy or treatment. States excluding services mandated by the judicial system include: FL, IL, OR, HI, and TN. Detoxification services also came up several times, but how states excluded or limited this service varied from not covering detox services at all to limiting the period one could use detox services to naming at what point during treatment detox coverage ends (e.g., no coverage when the treatment is no longer medically necessary).