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Mental Health Care Disparity: The Highs and Lows of Parity

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MENTAL HEALTH CARE DISPARITY: THE HIGHS AND LOWS OF PARITY LEGISLATION

Outstanding Note of the Year (2020)

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INTRODUCTION

Madisen "Maddie" Avery Vail was born on August 12, 1994 to Sally and Don Vail.[1] She grew up in Mystic, Connecticut,[2] a charming village located on the Mystic River that is popular with tourists in the summer months.[3]

Her mother, Sally, was a dentist, and her father, Don, was an insurance broker.[4] Maddie was one of five children; she had two brothers and two sisters.[5] The family had a dog and a horse, and they regularly enjoyed the outdoors at a sportsmen club.[6] Maddie loved art—a passion she shared with her older sister, Elena[7]—and she had a great sense of humor.[8] She enjoyed cooking, and dreamed of traveling around the world.[9]

Tragedy struck the family on Valentine's Day in 2012 when Maddie's younger brother, Owen, committed suicide.[10] That June, Maddie graduated from Stonington High School.[11] Following graduation, she became withdrawn, spending more and more time alone in her childhood bedroom.[12] Unbeknownst to her parents, Maddie, like

1. *Madisen Avery Vail*, LEGACY.COM (Jan. 28, 2016), https://www.legacy.com/obituaries/theday/obituary.aspx?n=madisen-avery- vail&pid=177483820 [https://perma.cc/V8FF-8WVH].
2. *Id.*
3. *See About Mystic*, THIS IS MYSTIC, https://thisismystic.com/about-mystic/ (last visited Sept. 6, 2020) [https://perma.cc/KWJ3-6HCB].
4. *They Fought a Daughter's Heroin Addiction and Their Insurer, at the Same Time*, MONEY (Dec. 21, 2016), https://money.com/insurance-claims-denial-addiction-mental-health/ [https://perma.cc/ZY6F-UPBC].
5. Libby Koponen, *Patch Whiz Kid Of The Week: Elena Vail,* PATCH (Mar. 21, 2011), https://patch.com/connecticut/stonington/patch-whiz-kid-of-the-week-elena-vail [https://perma.cc/TQ2J-RWHN].
6. *Id.*
7. *Id.*
8. LEGACY.COM, *supra* note 1.
9. *Id.*
10. *"Dyslexia Revealed" at Stonington High School*, THE YALE CENTER FOR DYSLEXIA & CREATIVITY: FROM THE DIRECTORS, http://www.dyslexia.yale.edu/articles_directors/dyslexia-revealed-at-stonington-high-school/ (last visited Jan. 25, 2020) [https://perma.cc/K6MK-CZN8].
11. Bree Shirvell, *Class Of 2012 Told To Set Sail But Watch The Tides*, PATCH (June 12, 2012), https://patch.com/connecticut/stonington/graduation-4fb9ba7c [https://perma.cc/8X7P-3DMN].
12. MONEY, *supra* note 4.

millions of other Americans, became a victim of the opioid epidemic.[13] At age nineteen, Maddie recognized she needed help and checked herself into a rehabilitation center with the help of a friend.[14]

Following Maddie's release from the rehabilitation center, she overdosed on heroin, and was rushed to the emergency room.[15] After four hours, she was discharged from the hospital, and her parents sent her to another residential treatment facility, where Maddie spent the next twenty days.[16] The residential treatment facility that had admitted Maddie was not in her parents' insurance network, so they had to borrow money to pay the $34,186 bill.[17] In-network providers are health care professionals and health care facilities that have contracted with an insurer's plan, whereas out-of-network providers have not contracted with the insurer's plan and result in higher out-of-pocket costs for the patient.[18]

Instead of focusing all of their energy on their daughter's recovery, Maddie's parents were forced into a battle with their insurer, United Healthcare. They submitted a claim to United Healthcare for partial reimbursement at the insurer's out-of-network rate but were denied coverage because they had not received pre-certification for Maddie's stay.[19] Maddie's parents appealed the denial, but the appeal was rejected because United Healthcare determined that residential treatment was not medically necessary.[20]

Unfortunately, Maddie lost her battle with addiction on January 25, 2016 at the age of 21.[21] Prior to her death, she spent three weeks in intensive care, including time on life-support.[22] Ironically, United Healthcare covered the entirety of Maddie's end-of-life medical care,

13. *Id.* An estimated two million Americans met the criteria for an opioid use disorder in 2018. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH (2019), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf [https://perma.cc/MM4X-JCMA].

14. MONEY, *supra* note 4.

15. *Id.*

16. *Id.*

17. *Id.*

18. CTRS. FOR MEDICARE & MEDICAID SERVS., WHAT YOU SHOULD KNOW ABOUT PROVIDER NETWORKS (March 2017), https://marketplace.cms.gov/outreach-and-education/what-you-should-know-provider-networks.pdf [https://perma.cc/7H2N-TYW7].

19. MONEY, *supra* note 4.

20. *Id.*

21. *Id.*

22. *Id.*

which cost more than twice as much as all of her addiction treatment had cost.[23]

Although Maddie's story is an extreme example of the disparity between insurance coverage for mental illnesses and substance use disorders (generally referred to as behavioral health care) and insurance coverage for medical and surgical services (generally referred to as physical health care), the details are all too common. Insurers frequently limit treatment coverage for behavioral health care by, for example, denying coverage for certain treatments, excluding certain disorders, and imposing more stringent reimbursement processes.[24] Dr. Brian Barnett, a psychiatrist who worked in an emergency room, recounts that he had to call insurance companies and provide justification in order to admit patients with mental illnesses, while his medical and surgical counterparts were able to admit patients for physical health care without making any phone calls.[25] Dr. Barnett has argued that those with mental health problems cannot "bear separate but equal treatment for much longer."[26]

Parity between behavioral and physical health care is especially important given the prevalence of mental illnesses and substance use disorders. It is estimated that twenty percent of adults over the age of eighteen suffer from a mental illness in a given year.[27] Mental illness is "a health condition that changes a person's thinking, feelings, or behavior (or all three) and that causes the person distress and difficulty in functioning."[28] A related, but separate concern, is that of substance use disorders.[29] Substance use disorders "affect[] a person's brain and behavior and lead[] to an inability to control the use of a legal or illegal

23. *Id.*

24. *See e.g.,* Kelsey N. Berry, Haiden A. Huskamp, Howard H. Goldman, Lainie Rutkow & Colleen L. Barry, *Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity*, 42 J. OF HEALTH POL., POL'Y & L. 1066 (2017).

25. Brian Barnett, *Insurance Companies Set An Unreasonable Bar For Mental Health Coverage*, HUFFINGTON POST (May 9, 2018), https://www.huffpost.com/entry/opinion-barnett-mental-health-insurance_n_5af210b1e4b00a3224ee0d42 [https://perma.cc/RQ7U-V8FN].

26. *Id.*

27. NAT'L INST. OF HEALTH, INFORMATION ABOUT MENTAL ILLNESS AND THE BRAIN (2007), https://www.ncbi.nlm.nih.gov/books/NBK20369/ [https://perma.cc/4EFA-GMQJ].

28. *Id.*

29. *Drug addiction (substance use disorder)*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/drug-addiction/symptoms-causes/syc-20365112##targetText=Drug%20addiction%2C%20also%22called%20substance,nicotine%20also%20are%20considerec%20drugs (last visited Jan. 20, 2020) [https://perma.cc/UE7P-5JT7].

drug or medication."[30] Because a mental illness may lead to addiction problems or an addiction may cause or worsen a mental disorder, many people with substance abuse problems also have mental health problems.[31] It is estimated that approximately one third of adolescents with a substance use disorder, and nearly half of adults with a substance use disorder, also have a diagnosed mental illness.[32]

Unfortunately, despite federal efforts at parity, insurance coverage for behavioral health care lags behind insurance coverage for physical health care.[33] Most states have enacted legislation regarding mental health parity, but many of these statutes fail to address the shortcomings of the federal laws. The purpose of this paper is to: 1) identify gaps in federal laws and other limitations to parity; 2) review state statutes that overcome some of these limitations; and 3) propose statutory revisions that state and federal legislatures should adopt.

Part I of this paper will provide background information on mental illnesses, substance use disorders and federal mental health parity laws. Part II will discuss barriers to mental health parity. Part III will analyze five different state mental health parity laws that have expanded upon the federal statutes, and Part IV will provide state and federal legislatures with recommendations for legislative change based on the preceding analysis. Part V will conclude.

I. BACKGROUND

Behavioral health care represents an unmet need for many Americans. This section will provide information on the severity, and impact, of mental illnesses and substance use disorders, making the case for why mental health parity is important. It will also provide an overview of federal legislation that has addressed mental health.

A. Mental Illnesses

Mental illnesses cause individuals both mental and physical distress. Symptoms may include feelings of extreme sadness, fear, or

30. *Id.*

31. *What is Addiction?,* AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/addiction/what-is-addiction (last visited Aug. 28, 2020) [https://perma.cc/BN6B-R6VC].

32. Substance Abuse and Mental Health Servs. Admin., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2017 NATIONAL SURVEY ON DRUG USE AND HEALTH (2018), https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report [https://perma.cc/T69V-2BUA].

33. *See* Wendy Yi Xu et al., *Cost-Sharing Disparities for Out-of-Network Care for Adults with Behavioral Health Conditions*, 11 JAMA NETWORK OPEN 1, 1 (2019) (finding that out-of-network costs were higher for behavioral health care than physical health care, even though total costs for physical health care were often higher).

anger; difficulty concentrating; suicidal thoughts; sleeping problems; changes in appetite; and physical ailments, such as headaches and stomach aches.[34] Further, people suffering from mental illnesses are more likely to avoid social activities and have trouble handling daily stressors.[35] Not surprisingly, mental illnesses represent four of the top ten causes of disability in America.[36]

It is estimated that twenty percent of adults over the age of eighteen suffer from a mental illness in a given year,[37] and that half of all Americans will be diagnosed with a mental illness at some point in their lifetime.[38] The prevalence is higher among women than men, and is higher among young adults than middle aged and older adults.[39] Of those adults with a mental illness, approximately forty-two percent had received treatment in the previous year.[40] Approximately twenty percent of children under the age of 18 are affected by mental illnesses, and an estimated two-thirds of them do not receive treatment.[41]

Possible reasons for not obtaining treatment include the stigma associated with mental illness[42] and a lack of access to treatment providers. Access to providers is affected by not having health

34. National Alliance on Mental Illness, *Warning Signs and Symptoms*, https://www.nami.org/learn-more/know-the-warning-signs (last visited Sept. 6, 2020) [https://perma.cc/9DW3-M56D].

35. *Id.*

36. NATIONAL INSTITUTES OF HEALTH, INFORMATION ABOUT MENTAL ILLNESS AND THE BRAIN (2007), https://www.ncbi.nlm.nih.gov/books/NBK20369/.

37. NAT'L INST. OF HEALTH, *supra* note 27.

38. *Data and Publications*, *Mental Health*, CDC, https://www.cdc.gov/mentalhealth/data_publications/index.htm (last visited Aug. 5, 2020) [https://perma.cc/YG45-ZA4Y].

39. *Mental Illness*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml [https://perma.cc/N5P3-MPS7] (last visited Aug. 28, 2020).

40. *Id.*

41. NAT'L INST. OF HEALTH, *supra* note 27.

42. *Id. See also* Stephen P. Hinshaw & Andrea Stier, *Stigma as Related to Mental Disorders*, 4 Ann. Rev. of Clinical Psychol. 367, 370 (2008).

insurance,[43] a shortage of mental health workers,[44] a disinclination of psychiatrists to accept insurance,[45] and a disinclination of insurance companies to include mental health providers in their network.[46] In addition to public stigma and discrimination, people with mental illnesses often internalize negative social messages, which may lead to greater distress and lower self-esteem.[47]

This lack of treatment is concerning, because mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy and cancer.[48] Mental illnesses are associated with lower use of medical care, reduced adherence to treatment therapies for chronic diseases, and higher risks

43. ROBIN A. COHEN ET AL., NAT'L. CTR. FOR HEALTH STATISTICS, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 2018 (2019), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201905.pdf [https://perma.cc/MP3X-ZML6] (finding that 30.4 million (9.4%) of Americans were uninsured in 2018).

44. PAMELA S. HYDE, U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT TO CONGRESS ON THE NATION'S SUBSTANCE ABUSE AND MENTAL HEALTH WORKFORCE ISSUES 10-11 (2013), https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork.pdf [https://perma.cc/4QBM-VU9V].

45. Tara F. Bishop, Matthew J. Press, Salomeh Keyhani & Harold Alan Pincus, *Acceptance of insurance by psychiatrists and the implications for access to mental health care*, 71 JAMA PSYCHIATRY 176 (2014) (finding that psychiatrists' acceptance rates of insurance were significantly lower than all other physician specialties acceptance rates). *See also* Steve Melek, Daniel Perlman & Stoddard Davenport, BOWMAN FOUND., *Addiction and Mental Health vs. Physical Health: Analyzing disparities in network use and provider reimbursement rates* 5 (2017), https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2017/nnqtldisparityanalysi.ashx (finding that mental health care providers were paid nearly 5% less than the Medicare Physician Fee Schedule amount whereas medical and surgical providers were paid approximately 11% more than the Medicare benchmark amount) [hereinafter Melek et al.]; and Tami L. Mark et al., *Differential Reimbursement of Psychiatric Services by Psychiatrists and Other Medical Providers*, 69 PSYCHIATRIC SERVICES 281, 283 (Mar. 1, 2018) (finding that psychiatrists were reimbursed less than nonpsychiatrist medical doctors for in-network services).

46. Cynthia Koons & John Tozzi, *As Suicides Rise, Insurers Find Ways to Deny Mental Health Coverage*, BLOOMBERG BUSINESSWEEK (May 16, 2019, 6:00AM), https://www.bloomberg.com/news/features/2019-05-16/insurance-covers-mental-health-but-good-luck-using-it [https://perma.cc/U2TE-FSJ7].

47. *See* Hinshaw & Stier, *supra* note 42, at 374.

48. *Learn About Mental Health*, *Mental Health,* CDC, https://www.cdc.gov/mentalhealth/learn/index.htm (last visited March 15, 2020) [https://perma.cc/5W5D-QL9B].

of adverse health outcomes.[49] On average, adults living with a mental illness die significantly earlier than those without a mental illness.[50] Reasons for these findings likely include the high prevalence of other chronic conditions among those with mental illnesses, such as diabetes and asthma.[51]

Additionally, mental health problems impose broader costs on society. For example, studies have shown that people with mental health problems are more likely to engage in violent behaviors and to need financial support.[52] Mental health disorders during childhood and adolescence affect development and possibly lead to more serious mental health problems in adulthood.[53] It is estimated that a quarter of homeless individuals have a serious mental illness, and a quarter of state prisoners have a mental health condition.[54]

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49. *Id.*

50. *See, e.g.*, Elizabeth R. Walker et al., *Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-analysis*, 72 JAMA PSYCHIATRY 5, 6 (2015), https://www.ncbi.nlm.nih.gov/pubmed/25671328 (finding the median years of lost life was 10 years for people with mental disorders) [https://perma.cc/6REQ-7UUN].

51. Joel E. Miller, Elizabeth Prewitt & Stephanie R. Sadowski, *Reclaiming Lost Decades: The Role of State Behavioral Health Agencies in Accelerating the Integration of Behavioral Healthcare and Primary Care to Improve the Health of People with Serious Mental Illness*, NASMHPD CORNERSTONES RESOURCE SERIES (May 2012), https://www.nasmhpd.org/sites/default/files/Reclaiming%20Lost%20Decades_Overview.pdf [https://perma.cc/7T8G-PM3C]. *But see* Valerie L. Forman-Hoffman, Pradip K. Muhuri, Scott P. Novak, Michael R. Pemberton, Kimberly L. Ault & Danyelle Mannix, *Psychological Distress and Mortality among Adults in the U.S. Household Population*, CBHSQ Data Rev. (Aug. 2014), https://www.samhsa.gov/data/sites/default/files/CBHSQ-DR-C11-MI-Mortality-2014/CBHSQ-DR-C11-MI-Mortality-2014.pdf [https://perma.cc/FF47-DHWB] (finding a higher death rate among those with mental illness after controlling for sociodemographic factors, chronic health conditions, and behavioral risk factors, such as smoking).

52. Goldman-Mellor, Caspi, Harrington, Hogan, Nada-Raja, Poulton & Moffitt, *Suicide Attempt in Young People: A Signal for Long-term Health Care and Social Needs,* JAMA Psychiatry 119 (2014).

53. Beata Mostafavi, *Half of U.S. Children with Mental Health Disorders Are Not Treated*, MICH. HEALTH LAB (Feb. 18, 2019, 8:16 AM), https://labblog.uofmhealth.org/rounds/half-of-us-children-mental-health-disorders-are-not-treated [https://perma.cc/859R-BTQ3].

54. *Mental Health Facts in America,* NATIONAL ALLIANCE ON MENTAL ILLNESS, https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf (last visited Sept. 6, 2020) [https://perma.cc/ZG7J-ZZDD].

B. Substance Use Disorders

In 2018, more than seven percent of Americans were living with a substance use disorder, representing more than twenty million people.[55] Thus, about 1 in 13 Americans needed substance use treatment in 2017.[56] Drug and alcohol dependence are similar to chronic conditions in that they are caused by a combination of genetic and environmental factors, requiring long-term adherence to treatment, and they have high relapse rates.[57] Addiction changes a person's brain functioning, including their ability to control their behavior and make decisions, and patients therefore need long-term or repeated episodes of treatment.[58]

Substance use disorders and substance misuse are estimated to cost the United States more than $400 billion in lost workplace productivity, health care expenses, and criminal justice involvement.[59] Approximately one-half of prisoners have substance use problems, but fail to receive treatment, leading to recidivism and relapse after release.[60] Additionally, alcohol and substance use are associated with a number of health problems, including cardiovascular disease, liver and pancreatic diseases, and hypertension.[61] Substance use also increases the risk for domestic violence, sexual assault, rape, and the contraction of communicable diseases.[62] While the nature of the relationship between substance use and these forms of violence is not well understood,[63] drug

55. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH 40 (2019), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

56. *Id.*

57. A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1693–94 (2000).

58. NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 2–3, 7, https://www.drugabuse.gov/node/pdf/675/principles-of-drug-addiction-treatment-a-research-based-guide-third-edition (last updated Jan. 2018) [https://perma.cc/LS2H-UWBU].

59. U.S. DEP'T OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 1-2, 1-12 (2016) [hereinafter FACING ADDICTION IN AMERICA], https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf [https://perma.cc/G35U-QUVQ].

60. NAT'L INST. ON DRUG ABUSE, *supra* note 58, at 19.

61. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 59 at 1–12.

62. *Id.* at 1-13–15.

63. *Id.* at 1-15.

and alcohol use lowers inhibitions and impairs the decision making ability of both perpetrators and victims.[64]

C. Federal Legislation

Early efforts at mental health care reform were largely unsuccessful. The National Mental Health Act of 1946 established the National Institute of Mental Health,[65] and after nearly two decades of work, the Mental Retardation Facilities and Community Mental Health Centers Construction Act was enacted in 1963 in order to de-institutionalize people with intellectual disabilities and mental illnesses through the construction of community mental health centers.[66]

Unfortunately, when mental hospitals closed, many of the community centers failed to address patient needs. Recognizing that the shift from institutional care to community-based care failed to provide for "chronically mentally ill individuals, children and youth, elderly individuals, racial and ethnic minorities, women, poor persons, and persons in rural areas," and that the mentally ill were underserved by Medicare and Medicaid, Congress enacted the Mental Health Systems Act in 1980.[67] The act included provisions that offered grants to support the care of these underserved individuals, and the funds were to be distributed to states following an application process in order to ensure accountability.[68] However, the act was repealed just one year later after the inauguration of Ronald Reagan.[69]

Congress's first attempt to enact a mental health parity law was the Mental Health Parity Act (MHPA) of 1996.[70] It applied to large

64. *See* Sarah DAWGERT, PA. COALITION AGAINST RAPE, SUBSTANCE USE AND SEXUAL VIOLENCE: BUILDING PREVENTION AND INTERVENTION RESPONSES (2009), https://www.pcar.org/sites/default/files/pages- pdf/substance_use_and_sexual_violence.pdf [https://perma.cc/4ZHD-DUQQ].

65. *Nat'l Inst. of Mental Health (NIMH),* NAT'L INST. OF HEALTH, https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh [https://perma.cc/H45V-2BG3] (last visited Jan. 24, 2020).

66. *See* Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282 (1963).

67. Mental Health Systems Act, Pub. L. No. 96-398, § 2, 94 Stat. 1564 (1980) (repealed 1981).

68. Gerald N Grob, *Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health*, 83 Milbank Q. 425, 447 (2005).

69. *Id.* at 449**;** Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 902, 95 Stat. 357 (1981).

70. Pub. L. No. 104-204 § 712.

group plans[71] and required comparable aggregate lifetime limits and aggregate annual limits for mental health benefits and medical and surgical benefits.[72] Aggregate lifetime limits are dollar limitations on the total amount of benefits that may be paid under a group health plan, and annual limits are dollar limitations on the total amount of benefits that may be paid within a twelve month period.[73] The act explicitly excluded benefits for substance use disorders,[74] and provided exemptions for all small group plans[75] as well as large group plans if the provision of comparable benefits would increase the cost of the plan by at least one percent.[76] The MHPA had a sunset date of September 30, 2001 that was extended annually until December 31, 2007.[77]

In 2008, the MHPA was superseded by the Mental Health Parity and Addiction Equity Act (MHPAEA).[78] The MHPAEA expanded parity requirements by mandating the provision of substance use disorder benefits.[79] It also expanded parity requirements by mandating that insurers impose financial requirements and treatment coverage limitations for mental illness and substance use disorders that are comparable to those imposed for medical and surgical care.[80] Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket expenses, whereas treatment limitations refer to the number of visits, days of coverage, and other limits on the scope or duration of treatment.[81] Although the MHPAEA expanded upon the MHPA, it also

71. Small employer plans were defined as employers who employed an average of at least 2, but no more than 50, employees during the past calendar year. *Id.* § 712(c)(1)(B).

72. *Id.* § 712(a).

73. 45 C.F.R. § 146.136 (2019).

74. Pub. L. No. 104-204 § 712(e)(4).

75. Small employer plans were defined as employers who employed an average of at least 2, but no more than 50, employees during the past calendar year. *Id.* § 712(c)(1).

76. *Id.* § 712(c)(2).

77. Amendment to the Interim Final Regulation for Mental Health Parity, 72 Fed. Reg. 41,230 (July 27, 2007) (to be codified at 48 C.F.R. pt. 146).

78. 29 U.S.C. § 1185(a) (2018).

79. 42 U.S.C. § 300gg-6 (2018).

80. *Id.*

81. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, THE CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet (last visited March 16, 2020) [https://perma.cc/NUE2-PKEY]. A deductible is the amount a person must pay for health care services before the insurance plan begins to pay. *Deductible*, HealthCare.gov, https://www.healthcare.gov/glossary/

provided exemptions for small employer plans[82] as well as plans that would increase in cost by two percent in the first plan year and one percent in subsequent plan years.[83] Further, it required parity only if the insurance plan offered mental health and substance use disorder benefits.[84] Therefore, insurance companies were not required to offer benefits for behavioral health care.

Enactment of the Patient Protection and Affordable Care Act (ACA)[85] in 2010 bolstered behavioral health care coverage in three notable ways. First, the ACA mandates behavioral health treatment coverage for certain plans, because mental illnesses and substance use disorders are included in the list of essential health benefits (EHB).[86] Specifically, plans that are offered through the state exchanges, individual and small group plans, and Medicaid expansion programs are required to include EHB.[87] Exchanges are health insurance marketplaces available in each state that help individuals and employers purchase and enroll in health insurance plans.[88] This expanded behavioral health care coverage to an estimated sixty-two

deductible/ (last visited Sept. 5, 2020) [https://perma.cc/32J2-3VPT]. A copayment is a fixed amount that a person must pay for health care services after the deductible is met. *Copayment*, HealthCare.gov, https://www.healthcare.gov/glossary/co-payment/ (last visited Sept. 5, 2020) [https://perma.cc/7EWX-CZLR]. Coinsurance is a percentage of costs that a person must pay for health care services after the deductible is met. *Coinsurance*, HealthCare.gov, https://www.healthcare.gov/glossary/co-insurance/ (last visited Sept. 5, 2020) [https://perma.cc/F3V6-F85C]. Out-of-pocket expenses refers to all costs for health care services that are not covered by a person's insurance plan. *Out-of-Pocket Costs,* HealthCare.gov, https://www.healthcare.gov/glossary/out-of-pocket-costs/ (last visited Sept. 5, 2020) [https://perma.cc/6D6P-HQCL].

82. Defined as employers "who employed an average of not more than 50 employees on business days during the preceding calendar year." Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5,410 (2010) (to be codified at 45 C.F.R. pt. 146).

83. 29 U.S.C. § 1185a(a)(2)(B) (2018).

84. 42 U.S.C. § 300gg-6.

85. Patient Protection and Affordable Care Act (ACA) of 2010, 42 U.S.C. §§ 18001-122 (2018).

86. 42 U.S.C. § 18022(b).

87. AMANDA K. SARATA, CONG. RSCH. SERV., R41768, MENTAL HEALTH PARITY AND MANDATED COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES AFTER THE ACA, at 6 (2012).

88. *Id.* at 2.

million Americans.[89] Second, the ACA prohibits annual and lifetime limits for EHB.[90] Third, the ACA mandates an external state or federal appeals process for adverse benefit determinations.[91]

II. BARRIERS TO MENTAL HEALTH PARITY

Although millions of Americans obtained insurance coverage under the ACA through Medicaid expansion, health insurance exchanges, and other regulations,[92] there remain a number of barriers to obtaining mental health care.[93] Barriers to parity between behavioral and physical health care include several gaps in federal laws, lack of access to mental health care, and obstacles making enforcement of parity laws difficult, if not impossible. This section will address these barriers in more detail.

A. Gaps in Federal Law

Gaps in the federal laws include the lack of a mandate for mental illness and substance use disorder benefits under the MHPAEA, exemptions to the ACA EHB requirements, inconsistent state benchmark plans, ambiguous terminology, and a lack of relevant information needed for enforcement. This section will discuss each of these in turn.

1. Exemptions

Some Americans are without behavioral health care coverage, even though they have insurance. The ACA mandates coverage for mental illnesses and substance use disorders for plans that are offered through the state exchanges, individual and small group plans, and Medicaid expansion programs.[94] Self-funded plans and large group plans offered outside of the state exchanges, however, are not subject to the EHB

89. Kirsten Beronio, Rosa Po, Laura Skopec & Sherry Glied, *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, U.S. DEP'T OF HEALTH & HUM. SERV. (Feb. 20, 2013), https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans [https://perma.cc/W4WJ-2GTB].

90. 29 C.F.R. § 2590.715-2711 (2019).

91. 45 C.F.R. § 147.136 (2019).

92. *See* David A. Rochefort, *The Affordable Care Act and the Faltering Revolution in Behavioral Health Care*, 48 INT'L J. OF HEALTH SERV. 223, 230 (2018).

93. *Id.* at 229.

94. SARATA, *supra* note 87, at 5.

requirements, although they still must comply with the MHPAEA.[95] Thus, although self-funded large group plans must provide comparable benefits for behavioral and physical health care if they provide benefits for behavioral health care, there is no mandate to provide benefits for behavioral health care.

In addition, the ACA requirements only apply to *new* individual, small group and state exchange plans.[96] Plans that were in existence on March 23, 2010 are considered "grandfathered plans."[97] Grandfathered plans remain exempt from ACA requirements as long as the plan's terms are not changed in certain ways, such as through the elimination of benefits for a particular condition, an increase in cost-sharing requirements, deductibles, out-of-pocket maximums, or copayments by a certain percentage, a decrease in an employer's contribution rate by a certain percentage, or the imposition of annual limits below specified amounts.[98] Grandfathered plans are not subject to the external appeals process or the EHB requirements, and in 2018, approximately twenty percent of insurers had at least one grandfathered plan.[99]

2. Benchmark Plans

Benchmark plans are used by insurers in a state as a standard for defining EHB coverage requirements for their individual and small group plans.[100] States were allowed to select their own benchmark plans regarding benefit standards based upon the largest plan in the state.[101] If a state did not select a benchmark plan, the default benchmark plan was the state's small group plan with the largest enrollment.[102]

95. *Id.* at 7; *Essential Health Benefits Bulletin*, CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT 5–6 (Dec. 16, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf [https://perma.cc/3KLN-TNXK].

96. SARATA, *supra* note 87, at 6.

97. U.S. DEP'T. OF LAB., COMPLIANCE ASSISTANCE GUIDE: HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW (2014), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf [https://perma.cc/E4K9-9A97].

98. *Id.*

99. *2018 Employer Health Benefits Survey*, KAISER FAM. FOUND. (Oct. 03, 2018), https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-13-grandfathered-health-plans/ [https://perma.cc/9ZMQ-SRAQ].

100. *See Benchmark Plan*, HEALTHINSURANCE.ORG, https://www.healthinsurance.org/glossary/benchmark-plan/ (last visited Jan. 26, 2020) [https://perma.cc/QHT8-6ZJY].

101. 45 CFR § 156.100 (2019).

102. *Id.*

Although benchmark plans must include coverage for EHB,[103] plan selections were made based on enrollment rather than quality. The result is that some state plans have much lower standards than others, including limitations of treatment services and quantitative treatment caps in violation of federal parity laws.[104] Although few studies have examined compliance among state exchange plans, the authors of one study found that, overall, seventy-five percent of plans in two state exchanges were compliant with parity requirements, but these results differed by state; only half of one state's plans appeared to be compliant.[105] In a comprehensive review of the substance use disorder benefits offered in 2017 benchmark plans, the National Center on Addiction and Substance Abuse found that approximately two-thirds of plans violated MHPAEA and ACA requirements in some way, and another one-third of plans did not provide enough information to determine whether there was parity.[106]

3. Ambiguity

Another gap in the federal laws is ambiguity. Because the MHPAEA and ACA do not define which conditions qualify as mental illnesses and substance use disorders,[107] these decisions are left up to state laws or insurers, meaning that some policies may cover certain behavioral health conditions while other policies do not cover that specific mental illness or substance use disorder. For example, Ohio's mental health parity law only requires parity for biologically based mental illnesses, which are defined as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder.[108] This list excludes conditions such as posttraumatic stress disorder, agoraphobia, and eating disorders.

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103. *Id.*

104. *See* Rochefort, *supra* note 92, at 230.

105. Kelsey N. Berry, Haiden A. Huskamp, Howard H. Goldman & Colleen L. Barry, *A Tale of Two States: Do Consumers See Mental Health Insurance Parity When Shopping on State Exchanges?*, 66 PSYCH. SERV. 565 (2015).

106. *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*, NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE (2016), https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-review-of-addiction-benefits-in-aca-plans [https://perma.cc/TZU2-3C94].

107. *Id.* at 1067. The MHPAEA states that a mental health condition "must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the [International Classification of Diseases] ICD, or State guidelines)." 45 C.F.R. § 146.136(a) (2019).

108. OHIO REV. CODE § 3923.282(A)(1) (2014).

Additionally, mental illnesses have more diagnostic and treatment ambiguity than other areas of medicine. The MHPAEA requires that benefits for behavioral health treatment must be comparable to benefits for physical health treatment, however, not all treatments or treatment settings for mental illnesses and substance use disorders correspond to those for medical and surgical conditions. Insurers are then able to limit coverage for treatment settings (e.g., residential services), services (e.g., certain therapies), and providers (e.g., social workers) that may be commonly used for mental illness and substance use disorders, but are not commonly used for medical and surgical care.[109] For example, a frequently litigated area of mental health parity is that for outdoor residential treatment programs, which are solely used for the treatment of mental illness and substance use disorders.[110] Insurers argue that there is no analogous medical or surgical treatment, and the plan is therefore compliant with MHPAEA requirements, whereas plaintiffs argue that skilled nursing facilities, inpatient rehabilitative facilities and inpatient hospice care centers represent analogous levels of treatment.[111]

4. Lack of Information

The United States Department of Labor has recognized that although some insurers intentionally skirt the law, many fail to comply simply because they lack relevant information.[112] This may in part be explained by the patchwork history of mental health parity laws: enactment of the MHPA in 1996;[113] a sunset provision that was extended annually for a total of six years;[114] enactment of the MHPAEA in 2008;[115] release of the interim final rules in 2010;[116] expansion of the MHPAEA with passage of the ACA in 2010;[117] and finally release of the

109. Berry et al., *supra* note 24, at 1091.

110. *See, e.g.*, Michael W. v. United Behav. Health, 420 F.Supp.3d 1207 (D. Utah Sep. 27, 2019); *see also* Sharon Cohen & Julia Zuckerman, *Spotlight on Litigation: Wilderness Therapy Programs,* 42 BUCK GLOB., LLC 1, 4–6 (2019).

111. *See United Behav. Health*, 420 F.Supp.3d.

112. U.S. DEP'T. OF LAB., IMPROVING HEALTH COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER PATIENTS 2 (2016) [hereinafter IMPROVING HEALTH COVERAGE].

113. Pub. L. No. 104-204 § 712.

114. Amendment to the Interim Final Regulation for Mental Health Parity, 72 Fed. Reg. at 41,230.

115. 29 U.S.C. § 1185a (2018).

116. Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5,410.

117. 42 U.S.C. §§ 18001–122 (2018).

final rules for the MHPAEA in 2013.[118] It is hard to follow the law when one does not know what the law is.

Further, although quantitative limits, such as copay dollar amounts, are easy to compare between behavioral and physical health care benefits, nonquantitative limits are more difficult to evaluate. The MHPAEA requires that nonquantitative limits—defined as the processes, strategies, standards and other factors used in determining benefits—for mental illness and substance use benefits must not be more stringent than those applied to medical and surgical benefits.[119] Examples of nonquantitative limits include requiring preauthorization for treatment services or prescriptions and imposing restrictions based on geographic locations or facility type.[120] There is a lack of guidance on how to measure or evaluate these factors, which makes monitoring parity difficult, if not impossible.[121] Through its enforcement activities,[122] the U. S. Department of Labor explains that it uses "specialized, interdisciplinary teams" to evaluate compliance issues such as the utilization of non-quantitative treatment limitations, and because of the complexity of these reviews, the teams include support from "regulatory subject matter experts and economists, as well as attorneys from [the Department of Labor's] Office of the Solicitor."[123] Even with these teams of experts, most of the investigations take over a year to complete.[124]

Despite expanded legislation regarding mental health parity, behavioral health insurance coverage accounts for a fraction of total health care spending. A large study of employer-sponsored insurance

118. 78 Fed. Reg. 68239 (Nov. 13, 2013).

119. *Id.* at 68244.

120. U.S. DEP'T OF LAB., *Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf (last visited Mar. 9, 2020) [https://perma.cc/372B- TBUA].

121. Berry et al., *supra* note 24, at 1068.

122. *See* R. ALEXANDER ACOSTA, U.S. DEP'T OF LAB., REPORT TO CONGRESS: PATHWAY TO FULL PARITY 4 (2018), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf [https://perma.cc/RN2G-84XM].

123. *An Introduction: DOL MHPAEA FY 2018 Enforcement Fact Sheet*, DEP'T OF LAB. (Sept. 5, 2019), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2018-fact-sheet-introduction.pdf [https://perma.cc/KXA6-3Y3B].

124. *Id.*

plans found that although spending for mental health and substance use disorder inpatient care has increased faster than for any other category of care, it accounted for a mere four percent of total health care spending in 2017.[125] Because of the gaps in federal laws, access to care is limited and insurance companies are able to restrict coverage of mental health care benefits.

B. Access to Care

Even though the ACA extended health insurance to millions of Americans, many individuals are still without health insurance, which means they must pay out-of-pocket for treatment, or forego it entirely. A recent study by the Centers for Disease Control and Prevention found that approximately thirteen percent of adults and five percent of children were uninsured in 2018.[126] Additionally, even those with health insurance may have unaffordable out-of-pocket expenses for behavioral health care resulting from out-of-network providers and higher copays and coinsurance costs, effectively making treatment unattainable. For example, a study comparing in-network and out-of-network usage for inpatient facilities, outpatient facilities, and professional office visits found that behavioral health care was provided out-of-network 3.6 to 5.8 times more often than physical health care, with higher instances of out-of-network care being provided at outpatient facilities.[127] Additionally, a study of health care expenses found that patients had substantially higher out-of-pocket expenses for mental illnesses, drug use disorders and alcohol use disorders than for diabetes and congestive heart failure.[128]

Research from the National Alliance on Mental Illness shows that behavioral health provider networks are narrower than networks for other medical providers,[129] meaning that many insured people lack access to behavioral health care providers. A recent study found that a quarter of individuals were unable to find a behavioral health provider in their network, compared to just one in ten who were unable to find

125. HEALTH CARE COST INST., 2017 HEALTH CARE COST AND UTILIZATION REPORT 10 (2019), https://www.healthcostinstitute.org/images/easyblog_articles/276/HCCI-2017-Health-Care-Cost-and-Utilization-Report-02.12.19.pdf [https://perma.cc/V4GF-3C2B].

126. COHEN ET AL., *supra* note 43.

127. Melek et al., *supra* note 45, at 3.

128. Xu et al., *supra* note 33, at 2, 7.

129. National Alliance on Mental Illness, *The Doctor is Out* (Nov. 2017), https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut.pdf [https://perma.cc/6L6J-T8EC].

a medical specialist in their network, resulting in greater out-of-pocket costs for mental health care.[130]

Insurance companies engage in such practices as listing providers who aren't taking new patients, who are no longer practicing or who are not in-network—known as providing "ghost networks"—and refusing to contract with providers.[131] For example, after moving to a new state for school, a woman had to contact more than fifty different providers before she found one that was willing to accept her as a new patient, and this provider ended up not being in her network.[132] Additionally, under current law, insurers are able to limit access to behavioral health care providers by limiting reimbursement rates. Studies have shown that insurers pay mental health providers less than what they pay other medical care providers, which makes it less likely that providers will opt in to a health plan's network.[133]

Insurers are also able to restrict mental health care benefits on a case-by-case basis by determining what is "medically necessary."[134] Medical necessity refers to coverage that is considered necessary to diagnose or treat illness "in accordance with generally accepted standards of medical practice," and the criteria used varies by insurer.[135] The medical necessity of behavioral health treatment is difficult to prove because evidence regarding the quality and effectiveness of behavioral health treatments is not as well developed as data on medical treatment for physical health conditions.[136] For example, one patient who was 5'7" and 100 pounds was denied inpatient treatment for her eating disorder because she was not underweight enough, and was forced to change insurance providers in order to obtain the medical care she so desperately needed.[137] A 2015 study found that denials for behavioral health care occur nearly twice as frequently as denials for

130. NAT'L ALL. ON MENTAL ILLNESS, OUT–OF–NETWORK, OUT–OF–POCKET, OUT–OF–OPTIONS 3 (Nov. 2016), https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/Mental-Health-Parity-Network-AdequacyFindings/Mental_Health_Parity2016.pdf [https://perma.cc/JC99-YFGL].

131. Koons & Tozzi, *supra* note 46.

132. *Id.*

133. Melek et al., *supra* note 45, at 2.

134. Graison Dangor, *Mental Health Parity Is Still An Elusive Goal In U.S. Insurance Coverage,* NPR (June 7, 2019), https://www.npr.org/sections/health-shots/2019/06/07/730404539/mental-health-parity-is-still-an-elusive-goal-in-u-s-insurance-coverage [https://perma.cc/8KSJ-H29R].

135. *See e.g.*, *Medical Necessity and the Law*, FindLaw, https://healthcare.findlaw.com/patient-rights/medical-necessity-and-the-law.html (last visited Aug. 28, 2020) [https://perma.cc/AA88-F5VC].

136. Dangor, *supra* note 134.

137. *Id.*

physical health care.[138] The most commonly denied mental health treatments are residential treatment, intensive outpatient treatment, psychological rehabilitation, partial hospitalization, home- or community-based therapy, and diagnostic tests.[139]

Although the ACA requires an independent external appeal process, initial determinations about whether treatment is medically necessary are made by a person who is employed by the insurer, which elicits concerns about biases. After all, an insurance company's business is to make money. Further, consumers may not be aware of their appeal rights under the ACA, and therefore they may fail to take advantage of them. And even if patients are aware of their rights, the appeals process can be time consuming, meaning patients must choose between delaying treatment or paying out-of-pocket while they seek coverage.[140]

C. Enforcement

A common criticism of mental health parity is that there is little monitoring of insurers, and therefore many of them do not comply with mental health parity laws.[141] The average insured person does not understand what mental health parity means, and thus does not pursue

138. NAT'L ALL. ON MENTAL ILLNESS, A LONG ROAD AHEAD 4 (Apr. 2015), https://www.nami.org/about-nami/publications-reports/public-policy-reports/a-long-road-ahead/2015-alongroadahead.pdf [http://perma.cc/AY8G-8EXQ].

139. *What To Do If You're Denied Care By Your Insurance*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Understanding-Health-Insurance/What-to-Do-If-You-re-Denied-Care-By-Your-Insurance [https://perma.cc/QL2P-JVTE] (last visited Jan. 18, 2020). Partial hospitalization is "an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder." *Partial Hospitalization*, NAT'L ASS'N OF PRIVATE PSYCHIATRIC HOSPITALS. AND THE AM. ASS'N FOR PARTIAL HOSPITALIZATION, 21 THE PSYCHIATRIC HOSP. 89 (1990).

140. After the patient submits the request for appeal and any relevant supporting documentation, the insurer has up to 30 days to complete the appeal process. *Appealing a Health Plan Decision: Internal Appeals*, HealthCare.gov, https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/ (last visited Sept. 5, 2020) [https://perma.cc/3VE8-YW6L]. If the appeal is not successful, the patient can submit a request for an external review, which may take up to 45 days. *Appealing a Health Plan Decision: External Review*, HealthCare.gov, https://www.healthcare.gov/appeal-insurance-company-decision/external-review/ (last visited Sept. 5, 2020) [https://perma.cc/4QLL-3HJQ].

141. *See, e.g.,* Steven Ross Johnson, *Mental Health Parity Remains a Challenge 10 Years After Landmark Law*, MODERN HEALTHCARE (Oct. 05, 2018, 01:00AM), https://www.modernhealthcare.com/article/20181005/NEWS/181009925/mental-health-parity-remains-a-challenge-10-years-after-landmark-law [https://perma.cc/NCY8-59M7].

an appeal to exercise their rights.[142] Further, the appeals process is often drawn out and arduous.[143]

At the federal level, the Department of Labor, Department of Health and Human Services, and the Department of Treasury have joint authority for ensuring compliance with the MHPAEA.[144] Specifically, the Department of Labor oversees employer-sponsored group plans, including those that are self-funded by the employer.[145] The Department of Health and Human Services has enforcement authority only when a state notifies the department that it is not enforcing the requirements, or when the department determines that a state is not enforcing the requirements.[146] The Department of Treasury has the authority to impose an excise tax on employers that are not in compliance with the MHPAEA.[147]

The Department of Labor has identified six common violations of the MHPAEA: 1) failing to offer benefits for mental health or substance use disorders; 2) charging higher copays for mental health care than those charged for medical and surgical care; 3) establishing more restrictive limits on visits for mental health care than for medical and surgical care; 4) requiring preauthorization for all mental health or substance use disorder treatments, but not for all medical and surgical care treatments; 5) requiring written treatment plans for mental health care but not for medical and surgical care; and 6) setting annual dollar limits for autism spectrum disorder treatment, but not for medical and surgical treatments.[148] In a 2018 report to congress, the Department of Labor stated that it had conducted 671 health plan investigations, resulting in 136 citations for MHPAEA violations.[149] For every investigation that was conducted, however, there were potentially many more violations that were missed. The Department of Labor has 400 investigators and it oversees over five million health, pension, life, and disability insurance plans, which means that each investigator would

142. ACOSTA, *supra* note 122, at 5.

143. MONEY, *supra* note 4.

144. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-150, MENTAL HEALTH AND SUBSTANCE USE: STATE AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES, 2 (2019). The MHPAEA amended the Employee Retirement Income Security Act, the Public Health Service Act, and the Internal Revenue Code such that the Departments of Labor, Health and Human Services, and the Treasury have joint jurisdiction over the MHPAEA. IMPROVING HEALTH COVERAGE, *supra* note 112, at 5.

145. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 144, at 13.

146. *Id.* at 12.

147. *Id.* at 13.

148. IMPROVING HEALTH COVERAGE, *supra* note 112, at 5.

149. ACOSTA, *supra* note 122, at 10.

need to review approximately 12,500 benefit plans.[150] In response to these resource constraints, the Department of Labor is focusing its reviews on insurance issuers, rather than individual plans.[151] One such investigation identified noncompliance that affected over 4,000 plans and seven million consumers.[152] As discussed above, the reviews are complex, and each one can take over a year to complete, meaning that many plans are simply not being reviewed.

In summary, Americans face a number of barriers to receiving behavioral health care benefits that are comparable to the benefits they receive for physical health care. As President Obama articulated at the National Conference on Mental Health in 2013, "less than 40 percent of people with mental illness receive treatment . . . We wouldn't accept it if only 40 percent of Americans with cancers got treatment. We wouldn't accept it if only half of young people with diabetes got help. Why should we accept it when it comes to mental health?"[153] Since federal laws and its enforcement falls short of providing Americans with behavioral health parity, it is vital to examine whether state laws fill the gaps.

III. ANALYSIS OF STATE LAWS

States have primary responsibility for overseeing the insurance plans sold within their state, with the exception of self-funded plans.[154] All states have statutes that regulate the business of insurance, but provisions vary widely regarding the regulation of behavioral health care benefits. This paper identifies five states that address some of the previously discussed concerns with implementation and enforcement of the federal statutes: Colorado, Connecticut, Illinois, Maine and Vermont. This section will discuss state statutes and identify provisions that provide clarity regarding the ambiguities discussed above, that address barriers to access, and that focus on compliance.

A. Gaps in Federal Laws

As discussed above, prior to the ACA, the MHPAEA did not mandate coverage, but only required large group plans to provide

150. DEP'T OF LAB., *supra* note 123.

151. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 144, at 24.

152. *Id.*

153. Remarks by the President at National Conference on Mental Health, OFFICE OF THE PRESS SECRETARY (June 3, 2013), https://obamawhitehouse.archives.gov/the-press-office/2013/06/03/remarks-president-national-conference-mental-health.

154. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 144, at 11–12.

comparable coverage *if* they offered mental health coverage.[155] Although the ACA mandates coverage for new small group and individual plans through the EHB, large group and grandfathered plans are only subject to the requirements of the MHPAEA. Thus, some individuals may have insurance coverage that does not include behavioral health care benefits because their large group plan or grandfathered plan has chosen not to offer mental health coverage. Some states, however, have enacted statutes that use mandatory language to require mental health care coverage. For example, Colorado requires that "every health benefit plan . . . must" provide coverage,[156] Illinois requires that "every insurer . . . shall" provide comparable coverage,[157] and Vermont requires that "any health insurance policy or health benefit plan offered by a health insurer . . . shall" provide coverage.[158] These states ensure that Americans with health insurance receive behavioral health care coverage regardless of their insurance plan. Additionally, the non-exempt plans that offer mental health care coverage are then subject to the MHPAEA parity mandate.

B. Providing Clarity

States have the opportunity to clarify many of the ambiguities left after enactment of the MHPAEA and ACA. As mentioned above, neither the MHPAEA nor EHB clearly define mental illnesses or substance use disorders. This gap allows insurers to exclude certain illnesses at their discretion. Some states have included specific and limited lists of covered mental illnesses in their statutes (e.g., schizophrenia, schizo-affective disorders, bipolar disorders, major depressive disorders, and obsessive-compulsive disorders).[159] However, such lists exclude other common mental health problems, such as anxiety, post-traumatic stress disorder, and eating disorders.

In contrast, other states provide broad definitions of mental illnesses and substance use disorders. For example, Kentucky defines mental illness as a "psychosis, neurosis or an emotional disorder,"[160] and Alaska defines substance use disorder as "a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances . . . ."[161] These broad definitions allow insurers to determine which illnesses are included within the meaning of those phrases.

155. AMANDA K. SARATA, CONG. RESEARCH SERV., R41249, MENTAL HEALTH PARITY AND MANDATED COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES AFTER THE ACA, 2 (2011).

156. COLO. REV. STAT. § 10-16-104 (5.5) (2019).

157. 215 ILL. COMP. STAT. 5/370c(a)(1) (2019).

158. VT. STAT. ANN. tit. 8, § 4089b(b)(1) (2018).

159. IOWA CODE § 514C.22(3) (2019).

160. KY. REV. STAT. ANN. § 304.17-318(1) (West 2018).

161. ALASKA STAT. § 21.42.365 (2019).

A third option some states have adopted is to refer to the definitions established by professional organizations. Specifically, Connecticut and Maine refer to any mental disorders as described in The Diagnostic and Statistical Manual of Mental Disorders,[162] Vermont refers to any condition or disorder listed in the International Classification of Diseases and Related Health Problems,[163] and Colorado and Illinois refer to any mental disorder as defined by either The International Statistical Classification of Diseases and Related Health Problems or The Diagnostic and Statistical Manual of Mental Disorders.[164] By using the definitions as provided by professional classification publications, these states include all mental illnesses and substance use disorders that are recognized by mental health providers. Further, the state statutes remain inclusive of behavioral health disorders as professional publications are updated based on research.

Because some treatment settings and services are unique to behavioral health care, insurers may avoid providing comparable benefits if there isn't a corresponding benefit for physical health care.[165] Although the MHPAEA final rules clarified that residential treatment centers are analogous to skilled nursing facilities, and thus benefits for residential treatment centers should be comparable to those for skilled nursing facilities, the rules did not further address the scope of services for mental illness and substance use disorders.[166] Some states have filled this gap by clarifying which services are covered. For example, Maine's statute explicitly states that medically necessary services include inpatient care, day treatment services (including psychoeducational techniques), outpatient services (including diagnostic processes), and home health care services.[167] Likewise, Connecticut's statute mandates that benefits include acute treatment services, psychiatric inpatient hospitalization and outpatient services, intensive outpatient services, partial hospitalization, intensive home-based services, family-focused therapy, inpatient psychiatric residential treatment, psychological and neuropsychological testing, trauma screening, and depression screening.[168] Additionally, the statute requires that care in a residential treatment facility be provided if a physician, psychiatrist, or clinical

162. CONN. GEN. STAT. § 38a-514 (2019); ME. STAT. tit. 24-A, § 2843 (2019).

163. VT. STAT. ANN. tit. 8, § 4089b(b)(2) (2018).

164. COLO. REV. STAT. § 10-16-104(d) (2019); 215 ILL. COMP. STAT. § 370(c) (2019).

165. *See* Discussion *infra* Part II.A.3.

166. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68239 (Nov. 13, 2013).

167. ME. REV. STAT. ANN. tit. 24-A, § 2843(5) (2019).

168. CONN. GEN. STAT. § 38a-514.

social worker determines that the insured cannot be safely or effectively treated in an acute care, partial hospitalization or outpatient setting,[169] which means the insurer cannot determine that the treatment is not medically necessary.

Similarly, to address the ambiguity of diagnostic and treatment services that are used for the treatment of substance use disorders, Connecticut's statute specifies that benefits are to include such specific services as substance use screening, detoxification services, rehabilitation services in residential treatment facilities, and family-based therapy for the treatment of juvenile substance use disorders.[170] Illinois's statute mandates coverage for medically supervised addiction treatment and stabilization services, including education and counseling, relapse prevention, and aftercare planning.[171] It also specifically states that treatment at residential treatment centers is included under coverage for inpatient care.[172]

C. Access

To address problems regarding access to providers, Vermont prohibits insurers from excluding any licensed mental health or substance use provider if the provider is willing to meet the terms of the plan.[173] This would help prevent the issue of narrow networks. Colorado mandates that insurers establish procedures that allow the insured person to receive treatment from an out-of-network provider if a service is not available within a reasonable time period or geographical distance from the insured person. The treatment must be provided at no greater cost than if it had been obtained from an in-network provider. This provision allows the insurance company to determine what "reasonable" means and would need to be monitored to ensure compliance.

Illinois's law is even more broad than Colorado's as it allows the insured person to select the provider of his or her choice. The insurer is required to pay the covered charges of the provider up to the limits of the policy, as long as the disorder or condition is covered by the policy and the provider is authorized to provide the services, regardless of whether the provider is considered in-network or out-of-network.[174] Given the problem of narrow networks for behavioral health care, Illinois's statute goes the furthest in addressing issues of access.

169. *Id.*

170. *Id.*

171. 215 ILL. COMP. STAT. 5/370c(b)(5.5) (2019).

172. *Id.* at (b)(9).

173. VT. STAT. ANN. tit. 8, § 4089b(c)(2) (2018).

174. 215 ILL. COMP. STAT. 5/370c (a)(2) (2019).

Because mental illnesses and substance use disorders may require long-term treatment, patients may not receive the care they need if their insurer limits the number of outpatient visits or days of inpatient treatment. Illinois requires large employer plans to cover a minimum of 45 days of inpatient care and 60 days of outpatient visits each year.[175] Although these minimum requirements recognize that behavioral health problems are more similar to chronic than acute illnesses and often require longer periods of treatment, they may not be adequate. Research has shown that most patients with substance use disorders, for example, need at least three months of treatment, and longer treatment is recommended.[176] Further research is needed to determine whether mandating a minimum number of inpatient days and outpatient visits is effective for both mental illnesses and substance use disorders, and if so, what the minimums should be.

If there is a dispute between the insurer and a provider regarding the medical necessity of a treatment, Illinois's statute requires that the insurer provide a mechanism for the insurer, the patient (or representative if the patient is unable to act for himself or herself), and the patient's provider to jointly select a provider that practices in the same specialty as the patient's provider that will conduct an independent review of the treatment. If the independent provider determines that the treatment is medically necessary, the insurer must provide reimbursement for it.[177] Further, the law states that the insurer must use criteria established by the American Society of Addiction Medicine in making medical necessity determinations for substance use disorders.[178] This is an important provision given that behavioral health care claims are denied more frequently than physical health care claims.[179]

D. Enforcement

Given that insurance regulation is primarily the responsibility of states,[180] states play an important role in the enforcement of parity laws. In a 2019 report, the U.S. Government Accountability Office revealed that while nearly all states review plans before they are approved for sale in their state, only about half of the states conduct some sort of review after individuals enroll in the plan.[181] State enforcement efforts range from more passive actions, such as requiring that insurers certify

175. *Id.* at (b)(4)(A)(i),(ii).

176. NAT'L INST. ON DRUG ABUSE, *supra* note 58, at 2–3.

177. 215 ILL. COMP. STAT. 5/370c (b)(3) (2019).

178. *Id.*

179. NAT'L ALL. ON MENTAL ILLNESS, *supra* note 138.

180. 15 U.S.C. § 1011 (2018).

181. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 144, at 15, 17.

they are compliant, to more active involvement, such as requiring that insurers provide evidence of compliance.

A Department of Health and Human Services report found that the most effective state practices include: 1) analyzing denials and appeals; 2) performing market conduct examinations, which involve an evaluation of insurers' policies and claim files; and 3) reviewing insurers' plans for network adequacy, including the processes and standards used to include providers in their networks.[182] For example, after conducting market conduct examinations of insurance providers, Pennsylvania's department of insurance fined Aetna $190,000 for violations related to copays, coinsurance, visit limits, and pre-authorization,[183] and United Healthcare $1,000,000 for denying or failing to cover claims related to mental health care.[184]

Many states, however, are failing to enforce parity laws. The U.S. Government Accountability Office found that thirteen states are not tracking consumer complaints, thirty-one states are not reviewing plans based on specific concerns, only nine states routinely review plans for parity compliance when they conduct market conduct examinations, and only eight states required insurers to submit a report or certification indicating compliance with parity requirements.[185] States reported that lack of resources and expertise were barriers to assessing compliance.[186] In response to state inaction, a Florida chapter of the National Alliance on Mental Illness recently drafted a legislative act that would require insurers in the state to submit annual reports

182. An estimated two million Americans met the criteria for an opioid use disorder in 2018. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH (2019), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf [https://perma.cc/N9H6-UZZH].

183. Harold Brubaker, *Aetna fined $190,000 by Pennsylvania over opioid addiction treatment coverage*, THE PHILA. INQUIRER, https://www.inquirer.com/business/aetna-health-insurance-opioids-autism-treatment-violations-20190108.html (Jan. 8, 2019) [https://perma.cc/D6P4-GASC].

184. Harold Brubaker, *United Healthcare fined $1 million by Pennsylvania for violations of mental-health law*, THE PHILA. INQUIRER, https://www.inquirer.com/business/health/unitedhealthcare-fine-1-million-pennsylvania-insurance-department-20191104.html (Nov. 4, 2019) [https://perma.cc/BP6X-KM7R].

185. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 144 at 17, 19, 20. These results include all 50 states plus the District of Columbia. *Id.* at 3.

186. *Id.* at 37.

regarding their efforts to ensure compliance.[187] Such reports would be a first step in identifying plans that are in need of improvement and holding insurers accountable.

Connecticut, for example, issues a "consumer report card" for each plan that includes information about the number or percentage of enrollees receiving behavioral health care services, including discharge rates and average lengths of stay at inpatient and outpatient facilities.[188] The statute states that the Commissioner shall analyze the data and that it "may" conduct investigations "to determine whether further action by the commissioner is warranted."[189] It fails, however, to provide any specificity regarding compliance with parity requirements. Likewise, Maine requires that each insurer submit a report to the Superintendent of Insurance each year describing the number and total amount of claims paid in the state for behavioral health services, distinguishing among those paid for inpatient, day treatment, and outpatient services.[190] The statute does not describe how or if the report is evaluated for parity, nor does it contain any enforcement provisions.

In contrast, Vermont's statute mandates that the Commissioner adopt rules regarding access to care, including network adequacy, and assessment of whether treatments are medically necessary.[191] Additionally, the Commissioner is to ensure that an annual "quality improvement project" is completed by insurers to facilitate the integration of services for behavioral and physical health care.[192] The statute further provides the Commissioner with authority to penalize insurers who are not in compliance, to order the insurer to cease and desist its violations, to require remediation, and to revoke or suspend the license of a health insurer.[193]

Illinois's statute has an even more comprehensive section related to compliance.[194] It requires the Department of Insurance to implement educational initiatives, including in-person trainings, webinars, and the establishment of a hotline.[195] It also provides for the establishment of a

187. Chorus Nylander, *Mental health discrimination: Fighting for insurance for mental health patients*, ABC3WEARTV (Oct. 30, 2019), https://weartv.com/news/local/mental-health-discrimination-fighting-for-insurance-for-mental-health-patients [https://perma.cc/MDD9-MDW6].

188. CONN. GEN. STAT. § 38a-478.

189. *Id.*

190. ME. REV. STAT. ANN. tit. 24-A, § 2843(7) (2019).

191. VT. STAT. ANN. tit. 8, § 4089b(d)(1)(b)(i-iii) (2018).

192. VT. STAT. ANN. tit. 8, § 4089b(d)(1)(b)(viii) (2018).

193. VT. STAT. ANN. tit. 8, § 4089b(d)(4)(A-D) (2018).

194. 215 ILL. COMP. STAT. 5/370c.1(h) (2019).

195. 215 ILL. COMP. STAT. 5/370c.1(h)(1) (2019).

workgroup comprised of mental health parity experts, behavioral health providers, Medicaid representatives and commercial insurance representatives.[196] The workgroup is authorized to measure and track compliance with parity laws through market conduct examinations and audits, and it is to provide recommendations to the state legislature.[197] A report based on the workgroup's findings is to be submitted to the General Assembly and be made available to the public.[198] Insurers are assessed fines and penalties for failing to comply with the statute, and those monies are used to support the Department's parity initiatives.[199]

Given the lack of resources at the federal level, and the responsibility of states in insurance regulation, it is imperative that states monitor insurers for compliance with the MHPAEA. In fact, a recent survey conducted by the U.S. Government Accountability Office found evidence of widespread instances of noncompliance. The survey found that seventeen states reported finding a total of 254 cases of noncompliance among insurers in 2017 and 2018.[200]

IV. LEGISLATIVE REFORM

The review of state statutes identified a number of optional approaches. Most importantly, behavioral health care coverage should be mandated. All Americans with health insurance should receive benefits for mental illnesses and substance use disorders in parity with medical and surgical benefits. This is especially important given the cost of mental illnesses and substance use disorders, both in terms of their co-morbidity with other diseases and the larger societal impact. Although insurers have raised concerns about cost, research has shown that the treatment of mental illnesses and substance use disorders could result in a reduction of medical and surgical costs, given that untreated behavioral health conditions are associated with a number of physical health conditions, including cardiovascular disease, liver disease, diabetes, and cancer.[201] As discussed in the interim final rules of the MHPAEA, states with mental health parity laws have seen either modest increases or lower costs and lowered premiums.[202]

196. 215 ILL. COMP. STAT. 5/370c.1(j) (2019).

197. 215 ILL. COMP. STAT. 5/370c.1(h)(2) (2019).

198. 215 ILL. COMP. STAT. 5/370c.1(h)(3) (2019).

199. 215 ILL. COMP. STAT. 5/370c.1(i) (2019).

200. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 144, at 29.

201. *See* Discussion *supra* Part I.

202. Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5,410; *see* Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.

The second important provision is to use professional diagnostic publications in lieu of broad definitions or specific lists of mental illnesses and substance use disorders. This practice ensures that insurance companies are providing benefits for all behavioral illnesses that are recognized by experts in the field.

State statutes that have addressed access issues represent another important provision. By clarifying the scope of services that should be covered by insurers, states prevent insurers from denying treatments and tests that are commonly used in the treatment of mental illnesses and substance use disorders, such as diagnostic screening and residential treatment. Additionally, allowing the insured to see out-of-network providers at in-network rates addresses the problem of narrow networks. As discussed above, the unaffordable high out-of-pocket costs resulting from out-of-network usage essentially makes treatment unattainable for many Americans,[203] and untreated mental health and substance use disorders are associated with chronic physical health conditions.[204] Thus, although increasing coverage at in-network rates may initially result in higher costs for insurers, treatment of behavioral health conditions should reduce overall costs over time.

The final important provision is the implementation of state-level procedures to monitor and enforce mental health parity laws. Illinois does the best job at this by providing educational trainings, tracking compliance, issuing fines and penalties for noncompliance, and making findings available to the legislature and the general public. Given the resource constraints at the federal level, it is imperative that states enforce mental health parity laws.

There are two ways that these legislative reforms could be adopted so that there is true parity between behavioral and physical health care insurance coverage: 1) each state could amend their individual statutes; or 2) federal legislatures could modify the MHPAEA to include the recommended provisions. One advantage to allowing each state to enact its own statute is that this bottom-up approach is more democratic and requires buy-in from state residents. Further, it allows states to "experiment" with precise terms, such as whether requiring a minimum of thirty inpatient days is effective.

There are, however, two main disadvantages to leaving parity laws up to the states. First, state insurance laws do not apply to self-funded

L. & MED. 471 (2012) for a literature review of costs and behavioral health care.

203. *See* Discussion *supra* Part II.B.

204. *See* Discussion *supra* Part I.

plans[205] or federally funded insurance, such as Medicare and Medicaid.[206] Approximately 60% of insured workers are covered by a self-funded plan, meaning 60% of insured workers are not protected by state parity laws.[207] Thus, full parity is not possible without a comprehensive federal law. Second, some states may be resistant to enacting more comprehensive statutes, just as many states resisted the expansion of Medicaid. This would result in inconsistencies across the country, with residents of some states receiving better behavioral health coverage than the residents of other states. Further, the lack of uniformity across states would make it difficult for national insurance providers to maintain compliance, as they would potentially need to ensure compliance with fifty different sets of standards.

As such, one advantage of amending the MHPAEA to include the above best practices is that of uniformity. It would ensure that all Americans—not just those in certain states or with certain plans—are protected by a comprehensive mental health parity law. Additionally, insurance providers would only have to look to one source for standards and guidance. However, the passage of federal law can be much more time consuming and complex given that any amendments would have to pass both houses of Congress. Thus, states should begin taking action now to reduce disparity in behavioral health care.

Despite the potential difficulty in amending the MHPAEA, it would be the more efficient way to address mental health parity. Thus, the longer-term goal is for Congress to amend the MHPAEA to: 1) mandate behavioral health care coverage; 2) use the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders to define which mental illnesses and substance use disorders are to be covered by insurers; and 3) further define the scope of services that are to be included as behavioral health care benefits. Individual states could still impose more stringent terms, such as allowing the insured to see out-of-network providers at in-network rates, and should monitor and enforce the federal and state parity laws.

CONCLUSION

Mental illnesses and substance use disorders are serious health concerns. Despite advances in ensuring that individuals receive the

205. Edward F. Shay, *B Regulation of Employment-Based Health Benefits: The Intersection of State and Federal Law in* EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 293, 310-11 (Marilyn J. Field & Harold T. Shapiro eds., 1993).

206. *See, e.g.,* 42 C.F.R. § 422.402 (2019).

207. Emily Bazar, *For Millions of Insured Americans, State Health Laws Don't Apply*, KAISER HEALTH NEWS (Nov. 16, 2017), https://khn.org/news/for-millions-of-insured-americans-state-health-laws-dont-apply/ (reporting that approximately 60% of insured workers are in a self-insured plan) [https://perma.cc/WB67-QNJ5].

behavioral health care treatment that they need, insurance benefits for mental illnesses and substance use disorders often fall short of those provided for medical and surgical care. This is, in part, because of gaps and ambiguities in the MHPAEA and ACA, barriers to accessing behavioral health care, and lack of enforcement. Some states have attempted to address these problems through comprehensive statutes. By amending the MHPAEA to include the states' best practices, Congress can ensure that all Americans have equal access to behavioral health care treatment coverage.